

Arthur L. Kerner

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P. 12



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5169

05159

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills, Md. c. LENGTH OF STAY IN 1b 61 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived, if institutional: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 234 North Stricker Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mabel Griffith Allen		4. DATE OF DEATH 5 24 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/15/88
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR: Months 24 Days 19 Hours 61 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dependent		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lawrence Allen - Deceased	
14. MOTHER'S MAIDEN NAME Elizabeth Griffith - Deceased		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Rosewood Records, Owings Mills, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic heart disease. Coronary Sclerosis DUE TO (c) Generalized arterio sclerosis, severe		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/10, 1899 to 5/24, 1961 , that (I) (we) last saw the deceased alive on 5/24, 1961 , and that death occurred at 5:35 p.m. the causes and on the date stated above.			
22a. SIGNATURE Dimitri Christov M.D.		22b. DATE SIGNED 5/25/61	
22c. PHYSICIAN'S NAME (Type) Dimitri Christov, M.D.		22d. ADDRESS Rosewood State Training School, Owings Mills	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 29, 1961	
23c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery		23d. LOCATION (City, town or county) (State) Owings Mills, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons		25a. REC'D BY REGISTRAR MAY 29 '61	
ADDRESS Reisterstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05161

Reg. Dist. No.

5170

FOR STATE
HEALTH DEPT.

TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a separate certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO 6 - OVERSEA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO 6 - OVERSEA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 52 Lyndale Ave.				e. STREET ADDRESS 52 Lyndale Ave.			
3. NAME OF DECEASED (Type or print) First ELISA Middle Antonelli Last Antonelli				4. DATE OF DEATH Month MAY Day 17 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/24/1894	
9. AGE (in years last birthday) 67 yrs.		10. FUNDING YEAR Months Days Hours Min.		11. BIRTH PLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? ITALY	
13. FATHER'S NAME GENNARONE CARFOGNA				14. MOTHER'S MAIDEN NAME THERESA POTETE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. DOMENICO A. ANTONELLI			
17. INFORMANT same				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 443X DUE TO Cardiac Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Hyper Tensive Cardio Vascular Disease (c) undent.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				Interval between onset and death Small			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John C. Hyle				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JOHN C. Hyle				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 5-17-61							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		5/22/61		Holy Redeemer		BALTIMORE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Ruck				24. REC'D BY REGISTRAR 5305 HARFORD Rd.			
24b. REGISTRAR'S SIGNATURE John S. Hays				DATE MAY 22 '61			

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RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE CENSUS
JAN 10 1900

U.S. DEPT. OF COMMERCE
BUREAU OF THE CENSUS

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FOR STATE
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5171 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05162

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON c. LENGTH OF STAY IN b. 4 YRS. 23 mos d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SHEPPARD & Enoch PRATT HOSP.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE OHIO b. COUNTY PORTSMOUTH c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PORTSMOUTH d. STREET ADDRESS 1107 RUHLMAN AVE.	
3. NAME OF DECEASED (Type or print) MARY ALICE VINCENT ARGANBUGHT		4. DATE OF DEATH MAY 21 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 20, 1897
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 63 Days 63	11. IF UNDER 24 HRS. Hours 63 Min. 63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) OHIO
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME BENJAMIN VINCENT	
14. MOTHER'S MAIDEN NAME LAURA YORK		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT NONE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation from Hanging 974X DUE TO Conditions, if any, which gave rise to immediate cause (b) Sudden (c) Sudden PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Sudden			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE		DATE	

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

5/22/61

Removal/Burial May 24, 1961

Greenmount Cemetery

Portsmouth, OHIO

John Burns Sons, Towson, Md.

MAY 24 '61

Arthur S. Francis

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

05163

5172

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN TB 7 Days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 737 Dolphin Street			
3. NAME OF DECEASED (Type or print) JOHN WALKER ARMSTEAD				4. DATE OF DEATH Month May Day 4 Year 1961			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH April 23, 1895	
9. AGE (In years last birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk (Retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. P. O.		9. AGE (In years last birthday) Months 4 Days 1 Hours 19 Min.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Henry Armstead				14. MOTHER'S MAIDEN NAME Lula Gay Walker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW-1				16. SOCIAL SECURITY NO. Clin Rec VAH Baltimore Md - Ft Howard Division			
17. INFORMANT Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA				INTERVAL BETWEEN ONSET AND DEATH 1 WEEK			
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.				(b) ARTERIOSCLEROTIC HEART DISEASE			
				(c) PEPTIC ULCER DUODENUM			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) BENIGN PROSTATIC HYPERTROPHY				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from April 27, 1961 to May 4, 1961 that () (we) last saw the deceased alive on May 4, 1961 , and that death occurred at 6:45 PM , from the causes and on the date stated above.							
22a. SIGNATURE <i>Thomas F. Crahan</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/5/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.				22d. ADDRESS VAH, BALTO. 18, MD., FT. HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-8-61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S Phillips				25a. REGULAR REGISTRAR 1808-10 N Monroe St Baltimore 17 Md		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Evans</i>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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General and Special Agents

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 28		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 28	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION 1006 Crosby Rd.		e. STREET ADDRESS 1006 Crosby Rd.	
J. NAME OF DECEASED (Type or print) First Lila Middle L Last Armstrong		4. DATE OF DEATH Month May Day 26 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1879
9. AGE (in years last birthday) 82		FUNDING YEAR IF UNDER 24 HRS Months 1 Days 26 Hours 19 Min 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZENSHIP OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Casper Slinkman	
14. MOTHER'S MAIDEN NAME Mary Hence		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. G. Alan Armstrong, 1006 Crosby Rd. Balto. 28	
18. CAUSE OF DEATH [Enter any one cause pertaining for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) fall from ladder, left lung DUE TO (b) 4-1-25 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Chronic white arteriosclerotic disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 15, 1927 to May 26, 1961 that (I, we) last saw the deceased alive on May 25, 1961 and that death occurred at 10:00 M. from the causes and on the date stated above			
22a. SIGNATURE Abraham B. Hurwitz		22b. LATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Abraham B. Hurwitz, M.D.		22d. ADDRESS 3403 Garrison Boulevard, Balto. Md.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE TIME May 26, 1961	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Loring B. Byers		25a. REC'D BY REGISTRAR MAY 31 1961	
25b. REGISTRAR'S SIGNATURE 8728 Liberty Rd. Randallstown, Md.		25c. REGISTRAR'S SIGNATURE	

INTERVAL BETWEEN ONSET AND DEATH



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05165

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL vs nearest town) <u>Freeland</u> c. LENGTH OF STAY IN 1b <u>1/2 hr.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>York</u> c. CITY OF TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shrewsbury</u> d. STREET ADDRESS <u>S. Main St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>O.</u> Last <u>ATTIG</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>28</u> Year <u>1961</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 26 / 1902</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years) <u>38</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u> 11. BIRTHPLACE (State or foreign country) <u>York Co., Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Miller</u>		14. MOTHER'S MAIDEN NAME <u>Annie Fishel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or in town) <u>No</u> (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____ 17. INFORMANT (Address) <u>Mary C. Attig, Shrewsbury, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broken neck</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASE CONDITION GIVEN IN PART I. (c) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Locomotive struck car in which he was a passenger</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> a.m. <u>5/28</u> 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Railroad crossing</u> 20f. (City or town) <u>Freeland</u> (County) <u>PA</u> (State) <u>Pa.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5/29/61</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		22a. NAME OF CEMETERY OR CREMATORY <u>Shrewsbury Lutheran</u> 22b. LOCATION (City, town, or county) <u>Shrewsbury, Penna.</u> (State) _____	
22c. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> 22d. DATE THEREOF <u>May 31, 1961</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac R. Kestner</u> ADDRESS <u>New Freedom, Pa.</u>	
24a. REG'D BY REGISTRAR <u>IN 2 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Charles E. France</u>		25. REGISTRAR'S SIGNATURE _____	

THIS CERTIFICATE OF DEATH IS TO BE FILED IN THE OFFICE OF THE CHIEF MEDICAL EXAMINER, BALTIMORE, MARYLAND, WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXPLAIN IN THE SPACE PROVIDED. THIS CERTIFICATE IS NOT VALID UNLESS IT IS SIGNED BY THE CHIEF MEDICAL EXAMINER OR HIS DEPUTY.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05166

5175

1. PLACE OF DEATH
a. COUNTY **Baltimore** MARYLAND
b. CITY OR TOWN if outside corporate limits write RURAL and give nearest town **Fort Howard**
c. LENGTH OF STAY IN 1b **265 days**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) **Veterans Administration Hospital**

2. USUAL RESIDENCE Where deceased lived if institution Residence before death
a. STATE **Maryland** b. COUNTY **Anne Arundel**
c. CITY OR TOWN if outside corporate limits, write RURAL and give nearest town **Annapolis**
d. 179 Green Street

3. NAME OF DECEASED
First Middle Last
JOHN B.F. BAILEY

4. DATE OF DEATH
Month Day Year
May 21 1961

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH
WIDOWED ☐ DIVORCED ☐ **July 27, 1888**

9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.
72 yrs

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Plumber**
10b. KIND OF BUSINESS OR INDUSTRY **Plumbing**
11. BIRTHPLACE **Annapolis, Maryland** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **James Bailey** 14. MOTHER'S MAIDEN NAME **Sophia King**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **Yes** 16. SOCIAL SECURITY NO. **214-30-6002** 17. INFORMANT **Clinical Records-1600 Loch Haven Blvd. Balto 18, Md.-F.O.T.H. DIVISION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **CALCIFIC AORTIC STENOSIS**
DUE TO (b) **GENERALIZED ARTERIOSCLEROSIS**
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last
DUE TO (c) **DIABETES MELLITUS**

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
DIABETES MELLITUS

19. Was a autopsy performed? YES ☒ NO ☐

20a. ACCIDENT OR NOT ACCIDENT OR CONTRIBUTING CAUSE OF DEATH IF EITHER NOTIFY MEDICAL EXAMINER
20b. DESCRIBE HOW INJURY OCCURRED Enter for each injury of 11 - Part I of file
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 20d. INJURY OCCURRED While at work Not While at work
20e. PLACE OF INJURY Home farm store street office bldg. etc.
20f. City, town, or county

21. I certify that ☒ (this hospital) attended the deceased from **August 29 1960** to **May 21 1961**, that ☒ (we) last saw the deceased alive on **May 21 1961**, and that death occurred at **A.M.** from the causes and on the date stated above.

22a. SIGNATURE **THOMAS F. CRAHAN, M.D.** 22b. DATE SIGNED **5/24/61**
22c. PHYSICIAN'S NAME TYPE **THOMAS F. CRAHAN, M.D.** 22d. ADDRESS **VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION**

23a. BURIAL, CREMATION REMOVAL (Specify): **Burial** 23b. DATE THEREOF **May 25 '61** 23c. NAME OF CEMETERY OR CREMATORY **Saint Annes Cemetery** 23d. LOCATION (City, town or county) **Annapolis, Maryland**

24. FUNERAL DIRECTOR'S SIGNATURE **John M. Taylor Sons** 25a. REC'D BY REGISTRAR **Gloucester Street** 25b. REGISTRAR'S SIGNATURE **Annopolis, Maryland** 25c. DATE **MAY 25 '61**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician and completely filled by the funeral director. After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9 59

1
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>MARYLAND</u> b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Pocomoke</u> c LENGTH OF STAY IN 1b <u>12 days</u> d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Rt. 1, Box 75</u>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>SOMERSET</u> c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Pocomoke</u> d STREET ADDRESS <u>Rt. 1, Box 75</u> e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>LEROY</u> Middle <u>THOMAS</u> Last <u>BALLARD</u> 4 DATE OF DEATH Month <u>5</u> Day <u>9</u> Year <u>1961</u>		5 SEX <u>M</u> 6 COLOR OR RACE <u>Negro</u> 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8 DATE OF BIRTH <u>2/19/1915</u> 9 AGE (in years lost birthday) <u>46</u> yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u> 10b KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u> 11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u> 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>HEWITT BALLARD</u> 14 MOTHER'S M A DEN NAME <u>ANNA MAE TURPIN</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.W.II ARMY 220-01-7072</u> 16 SOCIAL SECURITY NO. <u>220-01-7072</u> 17 INFORMANT <u>W. W. II ARMY 220-01-7072</u> Address <u></u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNG</u> DUE TO <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19 WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>0</u> m <u>0</u> p m. 20d INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work 20e PLACE OF INJURY (home, farm, factory, street, office bldg., etc.) 20f (City or town) <u></u> (County) <u></u> (State) <u></u>		21 I certify that <u>Dr. (this hasp tag)</u> attended the deceased from <u>4-27-1961</u> to <u>5-9-1961</u> that <u>he</u> (we) last saw the deceased alive on <u>5-9-1961</u> , and that death occurred at <u>2:00 PM</u> from the causes and on the date stated above 22a SIGNATURE <u>W. W. II ARMY 220-01-7072</u> M D ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b DATE SIGNED <u>5/9/61</u> 22c PHYSICIAN'S NAME (Type) <u>W. W. II ARMY 220-01-7072</u> 22d ADDRESS <u></u>	
23a R. R. A1: CREMATION <input type="checkbox"/> 23b DATE THEREOF <u>May 15-61</u> 23c NAME OF CEMETERY OR CREMATORY <u>COTTAGE GROVE</u> 23d LOCATION (City, town, or county) <u>Westover, Som. M.D.</u>		24 FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u> ADDRESS <u>Marion Ind</u> 25a REC'D BY REGISTRAR <u>W. W. II ARMY 220-01-7072</u> 25b REGISTRAR'S SIGNATURE <u></u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

05168

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>210 Riverside Rd.</u>		d. STREET ADDRESS <u>210 Riverside Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>COMPTON M. BARNES</u>		4. DATE OF DEATH <u>MAY 12 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/14/1890</u>
9. AGE (In years last birthday) <u>71</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PLASTIC CO.</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>William M. Barnes</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Monnett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>210 Riverside Rd. BALTO. 25, Md.</u>		18. MRS. <u>CARRIE E. BARNES</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of Lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-1 1955</u> to <u>5-12 1961</u> , that I last saw the deceased alive on <u>5-12 1961</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Eugene Schmitzer</u> MD		ADDRESS (Street, city or town, state) <u>3904 S. Hanover St. BALTO. MARYLAND</u>	
PHYSICIAN'S NAME (Type) <u>Eugene Schmitzer, M.D.</u>		DATE SIGNED <u>5-12-61</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 15, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. TRUMAN SCHWAB</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>MAY 1 1961</u>		24b. REGISTRAR'S SIGNATURE <u>Clifton S. ...</u>	

3512 Frederick Ave. (29.)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5178

05169

1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside of corporate limits write RURAL and give nearest town) Fort Howard
c. LENGTH OF STAY in lb 81 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital

2. USUAL RESIDENCE Where deceased lived (institution Resid. n.g. bu. add. exp.)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) 606 North Gilmore Street
d. STREET ADDRESS 17

3. NAME OF DECEASED (Type or print)
First JOSEPH Middle H. Last BARNES

4. DATE OF DEATH
Month May Day 9 Year 1961

5. SEX Male 6. COLOR OR RACE Colored 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH
Month 4 Day 19 Year 1919

9. AGE (in years last birthday) 41 yrs. 10. IF UNDER 1 YEAR Months 1 Days 19 11. IF UNDER 2 HRS. Hours 19 Min 61

12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter
12b. KIND OF BUSINESS OR INDUSTRY Self employed
12c. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
12d. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Johnny Barnes 14. MOTHER'S MAIDEN NAME Tillie Norris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes 16. SOCIAL SECURITY NO. 218-10-7866 17. INFORMANT Clinical Records VAH, 3900 Loch Raven Blvd. Balto. Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. ARTERIOSCLEROTIC HEART DISEASE WITH INFARCTION
MULTIPLE PULMONARY INFARCTIONS

19. INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS + 15 YEARS + 4 YEARS
20. UNKNOWN UNKNOWN

21. I certify that (X) (this hospital) attended the deceased from April 8, 1961 to MAY 9, 1961, that (X) (we) last saw the deceased alive on May 9, 1961, and that death occurred at 11 A.M. from the causes and on the date stated above

22a. SIGNATURE Thomas F. Crahan M.D. 22b. DATE SIGNED 5/9/61

22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D. 22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION

23a. BURIAL, CREMATION, 23b. DATE THEREOF Burial 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. 23d. LOCATION (City, town or county) Baltimore (State) 20, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE Marshall Hayes ADDRESS 638 N. Gilmore St., Balto. Md. 25a. REC'D BY REGISTRAR MAY 10 61 25b. REGISTRAR'S SIGNATURE

26. MEDICAL CERTIFICATION
26a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)
26b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
26c. TIME OF INJURY Month, Day, Year 19 26d. INJURY OCCURRED While at work ☐ Not While at work ☐ 26e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
26f. (City or town) (County) (State)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the attending physician and complete certificate be filed in by the funeral director. After this certificate has been signed by the attending physician and complete certificate be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

05170

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a STATE Maryland b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c LENGTH OF STAY IN 1b Essex (21)	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 962 Renfrew Street		d STREET ADDRESS 962 Renfrew Street	
3 NAME OF DECEASED (Type or print) First Middle Last BETTY LORRAINE BAUGHER		4 DATE OF DEATH Month Day Year May 17th, 1961	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 22, 1925
9a AGE (in years last birthday) 36		9b FUNDERS 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY New Jersey	
11 BIRTHPLACE (State or foreign country) USA		12 CITIZEN OF WHAT COUNTRY USA	
13 FATHER'S NAME Herbert F. Holmes		14 MOTHER'S MAIDEN NAME Mercy V. Templin	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16 SOCIAL SECURITY NO. 148-16-6087	
17 INFORMANT D.G. Baugher		Address same as #2	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 192.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 7 YRS.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from JULY 1955 to 17 MAY 1961 , that I last saw the deceased alive on 9 MAY 1961 , and that death occurred at 12:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 1105 Old Eastern Avenue DATE SIGNED 5/18/61 ACTUAL SIGNATURE Morris Rainess PHYSICIAN'S NAME (Type) Morris Rainess, M.D. Baltimore 21, Maryland			
22a BURIAL CREMATION REMOVAL (Specify) Burial	22b DATE THEREOF 5/20/61	22c NAME OF CEMETERY OR CREMATORY Bel Air Memorial	22d LOCATION (City, town or county) (State) Bel Air, Maryland
23 FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md		24a REC'D BY REGISTRAR MAY 22 '61	
24b REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05171

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution on Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 9yr7mth24days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 2830 Lake Avenue	
3. NAME OF DECEASED (Type or print) First Mary Middle BAUMMER Last (Baumer)		4. DATE OF DEATH Month May Day 18 Year 1901	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1891
9. AGE (In years last birthday) 69 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic		10b. KIND OF BUSINESS OR INDUSTRY housework	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Palmer C. BAUMMER		14. MOTHER'S MAIDEN NAME Katherine Kennett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter on only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute congestive Heart failure 410x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Cardiac hypertrophy and dilatation DUE TO (c) Rheumatic mitral valvulitis with deformity		INTERVAL BETWEEN ONSET AND DEATH 15 minutes years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1957 to May 18, 1901 , that I last saw the deceased alive on May 18, 1961 , and that death occurred at 12:30 P. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Stella Wachslar M. D.		SPRING GROVE STATE HOSPITAL 5-18-01	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 26, Maryland	
22a. BURIAL, CREMATON, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5/20/61	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	22d. LOCATION (City, town, or county) (State) BALTIMORE MD.
23. FUNERAL DIRECTOR'S SIGNATURE H. J. Ruck		24a. REC'D BY REGISTRAR 5305 HARFORD Rd.	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05172

1 PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. STATE

Maryland

c. COUNTY

Baltimore

b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)

Baldwin

c. LENGTH OF STAY (In days)

d. CITY OR TOWN (If outside corporate limits write RURAL)

Baldwin

d. NAME OF HOSPITAL OR INSTITUTION (If in hospital, give street address)

Baldwin Mill Road

e. STREET ADDRESS

Baldwin Mill Road

f. RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED

First Middle Last

Joseph A.

Billingslea

4 DATE OF DEATH

Month Day Year

May 16th 1961

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

June 7 1879

9. AGE (in years last birthday)

81 yrs.

10. MONTHS

01

11. DAYS

12

12. HOURS

11

13. MIN.

00

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ret. Electrical Contractor

10b. KIND OF BUSINESS OR INDUSTRY

Ohio

13. FATHER'S NAME

Fleming Billingslea

14. MOTHER'S MAIDEN NAME

? 4th St

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

179-12-6592

17. INFORMANT

Mrs. Lillian M. Billingslea

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Coronary Thrombosis
Arteriosclerotic Cardiovas. Dis

INTERVAL BETWEEN ONSET AND DEATH

15 min. 11 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

Duodenal Ulcer

20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY

Hour o.m. p.m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town

County

(State)

21 I certify that (I) (this hospital) attended the deceased from 9-18-61 to 5/16-61, that (I) (we) last saw the deceased alive on 5/16-61, and that death occurred at 9:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Clifford F. Hudson

ATTENDING PHYS

22b. ADDRESS

FORK, MD.

23a. BURIAL, CREMATION, 23b. DATE THEREOF

REMOVAL (Specify)

5-18-61

23c. NAME OF CEMETERY OR CREMATORY

MT. MORIAH

23d. LOCATION (City, town or county)

Baltimore

24 FUNERAL DIRECTOR'S SIGNATURE

Clifford F. Hudson

ADDRESS

5305 Maryland

25a. REC'D BY REGISTRAR

DATE MAY 18 '61

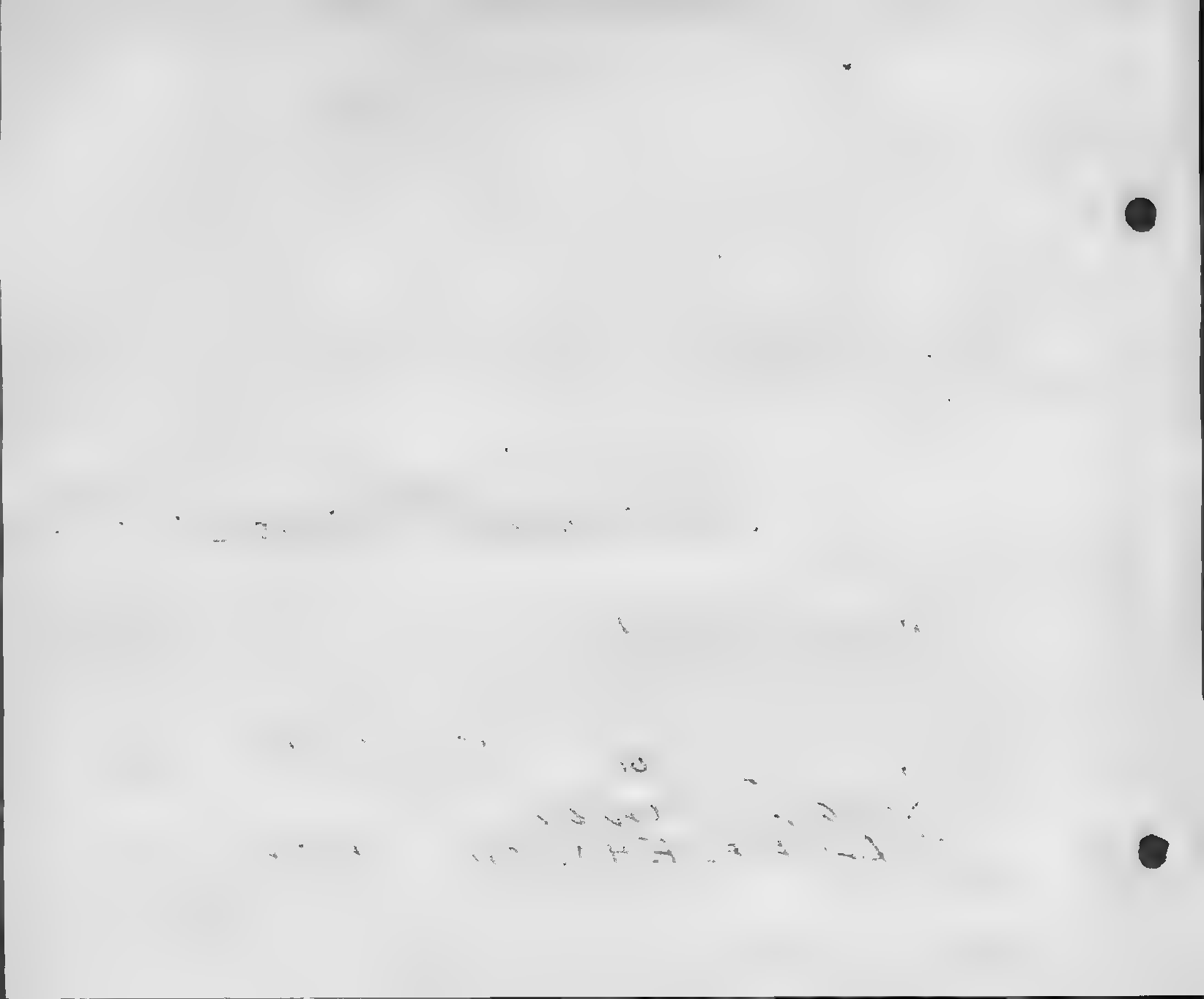
25b. REGISTRAR'S SIGNATURE

Clifford F. Hudson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, please remove the certificate from the file and retain it for use as the burial-transit permit. The certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



1
FOR STATE
HEALTH DEPT.

M

I

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

180
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05173

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7809 Lockwood Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> d. STREET ADDRESS <u>7809 Lockwood Road</u>	
3. NAME OF DECEASED (Type or print) <u>LUCILLE</u> First Middle Last 4. DATE OF DEATH <u>May 26 1961</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>5-27-1-31</u> 9. AGE (In years, last birthday) <u>29</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>USA</u> 12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>John</u> 14. MOTHER'S MAIDEN NAME <u>Mrs. King</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>123-45-6789</u> 17. INFORMANT <u>W. Bradley King, Jr., M.D.</u> Address <u>1234 Main St., Baltimore, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute leukemia</u> DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>5</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I look charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <u>W. Bradley King, Jr., M.D.</u> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5/27/61</u> Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF <u>5-27-61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u> 22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR <u>James H. King</u> ADDRESS <u>1234 Main St., Baltimore, Md.</u> 24a. REC'D BY REGISTRAR <u>James H. King</u> DATE <u>MAY 31 '61</u> 24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

Reg. Dist. No.

05174

5183

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>27 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		d. STREET ADDRESS <u>2508 W. Balto. St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>E.</u> Last <u>Bowers</u>		4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-16-88</u>
9. AGE (In years last birthday) <u>72</u>		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>pipe fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTH-PLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Bowers</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Flannery</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Records: Spring Grove State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<u>Chronic Brain Syndrome assoc. with Cerebral Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 25, 1934</u> to <u>May 19, 1961</u> , that I last saw the deceased alive on <u>May 19, 1961</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Jose R. Arizaga</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Spring Grove State Hospital 5/20/61</u>	
PHYSICIAN'S NAME (Type) <u>Jose R. Arizaga, M.D.</u>		<u>Baltimore 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAY 22, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>	22d. LOCATION (City town or county) (State) <u>BALTIMORE Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. McNeil</u>		ADDRESS <u>Balt 28, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 22 1961</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed in the hospital or attending physician's file. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CAL EXAMINER: This certificate should be executed within 24 hours after death. If a physician is unable to execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, and its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1 PLACE OF DEATH
2 COUNTY

Baltimore

b CITY OR TOWN if outside corporate limits
w/ 10+ RURAL and 4 or more past 10 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3 NAME OF
DECEASED
TOLSON

5 SEX

Male	White
------	-------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

13. FATHER'S NAME

JESSE S. BRADFORD SR.

HE WAS DECEASED EVER IN THE ARMED FORCES
Y. ... OF ... (b) (5), view or dates of observ

1B CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART. PER 50 IN. (ANT CONL COME CONTR 9 TING TO DEATH 9 AT NOT RELATED TO THE TERMINAL DISEASE CONDITION) (EN 1/2)

ZUB EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of 19m 1B.)

20- TIME OF INJURY
Hour a.m.
P.M.

Month Day Year

19

20d INJURY OCCURRED
While Not While
at work at work

PLA E OF INJURY (Home, tavern,
factory, street, office bldg., etc.)206 *Journal of Management Inquiry* 12(2)

21 I certify that I in charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINEE'S
NAME

228 R. R. L. CREMATION

DATE THEREOF

22c NAME OF CEMETERY OR CREMATORY

24d. LOCATION City, town or country

REMOVED Specify
BURIAL MAY 11, 1961, MT. CARMEL

43. EMERALD D RECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE _____

8. W. Hoffmann 3218 HUDSON ST. (24)

NAV 10 '61

Chlorophyll *a* Fluorescence



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any page is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9 60

M

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3319 Acton Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3319 Acton Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3319 Acton Road		d. STREET ADDRESS 3319 Acton Road	
3. NAME OF DECEASED (Type or print) AUDREY BERNICE BRAUN		4. DATE OF DEATH Month May Day 11 Year 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-13-1931	
9. AGE (in years last birthday) 30 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William C. M. Innis		14. MOTHER'S MAIDEN NAME MARION YOUNG	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 64-26-4489- Miss MARION M. Innis	
17. INFORMANT Miss MARION M. Innis		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of chest, near-contact, with penetration of heart and massive internal hemorrhage DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Shot self in chest	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot self in chest	
20c. TIME OF INJURY Hour 4:15 p.m. Month 5/11 Year 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. City or town; (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.		DATE SIGNED 5/12/61	
22a. BURIAL CREMATION, (Specify) BURIAL		22b. DATE THEREOF 5-15-61	
22c. NAME OF CEMETERY OR CREMATORY GARDENS FARM		22d. LOCATION (City, town, or country) (State) Baltimore Md.	
23. FUNERAL DIRECTOR Arthur S. King		24. REC'D BY REGISTRAR May 15 1961	
24b. REGISTRAR'S SIGNATURE Arthur S. King			





TO HO: PH: 4
TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death, and it should be relayed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5187

05178

1. PLACE OF DEATH
a. COUNTY **Baltimore** MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Baltimore** LENGTH OF STAY IN 1b
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Baltimore**
d. NAME OF HOSPITAL OR INSTITUTION (if not hospital, give street address) **10 Gunpowder Road** d. STREET ADDRESS **10 Gunpowder Road**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived, if not full-time residence before admission)
a. STATE **Maryland** b. COUNTY **Baltimore**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Baltimore**
d. STREET ADDRESS **10 Gunpowder Road**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) **MARIE F.F. Burhop**
4. DATE OF DEATH **May 18, 1961**
5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **Jan. 8, 1888**
9. AGE in years (last birthday) **73** yrs IF UNDER 1 YEAR: Months **1** Days **18** IF UNDER 2 HRS: Hours **1** Min. **18**
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife** 10b. KIND OF BUSINESS OR INDUSTRY **Austria** 11. BIRTHPLACE (County, State, or country) **USA**
12. CITIZEN OF WHAT COUNTRY? **USA**
13. FATHER'S NAME **Ernest Fredericks** 14. MOTHER'S MAIDEN NAME **Frances (Unknown)**
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** SOCIAL SECURITY NO. **1** INFORMANT **Mrs. Rolfe Pottberg-Glen Arm Rd. 34** Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **Bronchopneumonia**
(b) **Cerebral Thrombosis + Hemiplegia**
(c) **Arteriosclerosis**
DUE TO **10 days**
DUE TO **3 years**
DUE TO **6+ years**
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I **Diabetes Mellitus**
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
21c. TIME OF INJURY Month **May** Day **18** Year **1961** 21d. INJURY OCCURRED While at work ☐ Not While at work ☐ 21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **Home** 21f. City or town **Baltimore** County **Baltimore** State **Md.**
21. I certify that (I) **(this hospital)** attended the deceased from **July 1, 1955** to **May 18, 1961**, that (I) **(the)** last saw the deceased alive on **May 18, 1961**, and that death occurred at **9:20 P.M.** from the causes and on the date stated above.
22a. SIGNATURE **Charles E. Shaw, M.D.** ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐ 22b. DATE SIGNED **5/19/61**
22c. PHYSICIAN'S NAME (Type) **Charles E. Shaw, M.D.** 22d. ADDRESS **5801 Loch Raven Blvd., Rm 1012**
23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **5/22/61** 23c. NAME OF CEMETERY OR CREMATORY **Prospect Hill** 23d. LOCATION (City, town or county) **Flemington, New Jersey** (State) **N.J.**
24. FUNERAL DIRECTOR'S SIGNATURE **Wm Cook-Towson, Inc. 1050 York Rd. Towson Md.** ADDRESS **1050 York Rd. Towson Md.** 25a. REC'D BY REGISTRAR **MAY 22 '61** 25b. REGISTRAR'S SIGNATURE **Arthur P. France**



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05180

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b 22 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1700 Bayard Avenue		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk - 22 d. STREET ADDRESS 1700 Bayard Avenue e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle BURKHARDT Last Sr.		4. DATE OF DEATH Month May Day 19 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1886
9. AGE (In years last birthday) 74 yrs.		10. FUND (YEAR) Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) plumber		10b. KIND OF BUSINESS OR INDUSTRY retired	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Burkhardt	
14. MOTHER'S MAIDEN NAME Fredericka Judd		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 214-18-6211		17. INFORMANT Mrs. Marie L. Burkhardt-1700 Bayard Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO A-S-C-V DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. Davis M.D.		DATE SIGNED 5/20/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/22/61	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. Sander & Sons, Inc., Baltimore, Md.		24a. REC'D BY REGISTRAR 22 01	24b. REGISTRAR'S SIGNATURE Clifton S. Smith

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



CERTIFICATE OF DEATH

Reg. Dist. No.

05181

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>1yr6mth24dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. STREET ADDRESS <u>4209 Edmondson Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Estelle</u> Middle <u>Burriss</u> Last <u>Burriss</u>		4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 20, 1881</u>
9. AGE (In years last birthday) <u>80</u> yes		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>unknown</u>	
14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>unknown</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senile Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 15, 1959</u> to <u>May 14, 1960</u> , that I last saw the deceased alive on <u>5-13-</u> , 19 <u>61</u> , and that death occurred at <u>1:35 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ricardo Ebaney</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL</u> <u>5/14/61</u>	
PHYSICIAN'S NAME (Type) <u>Ricardo Ebaney</u>		<u>Catonsville 26, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 17, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

5190

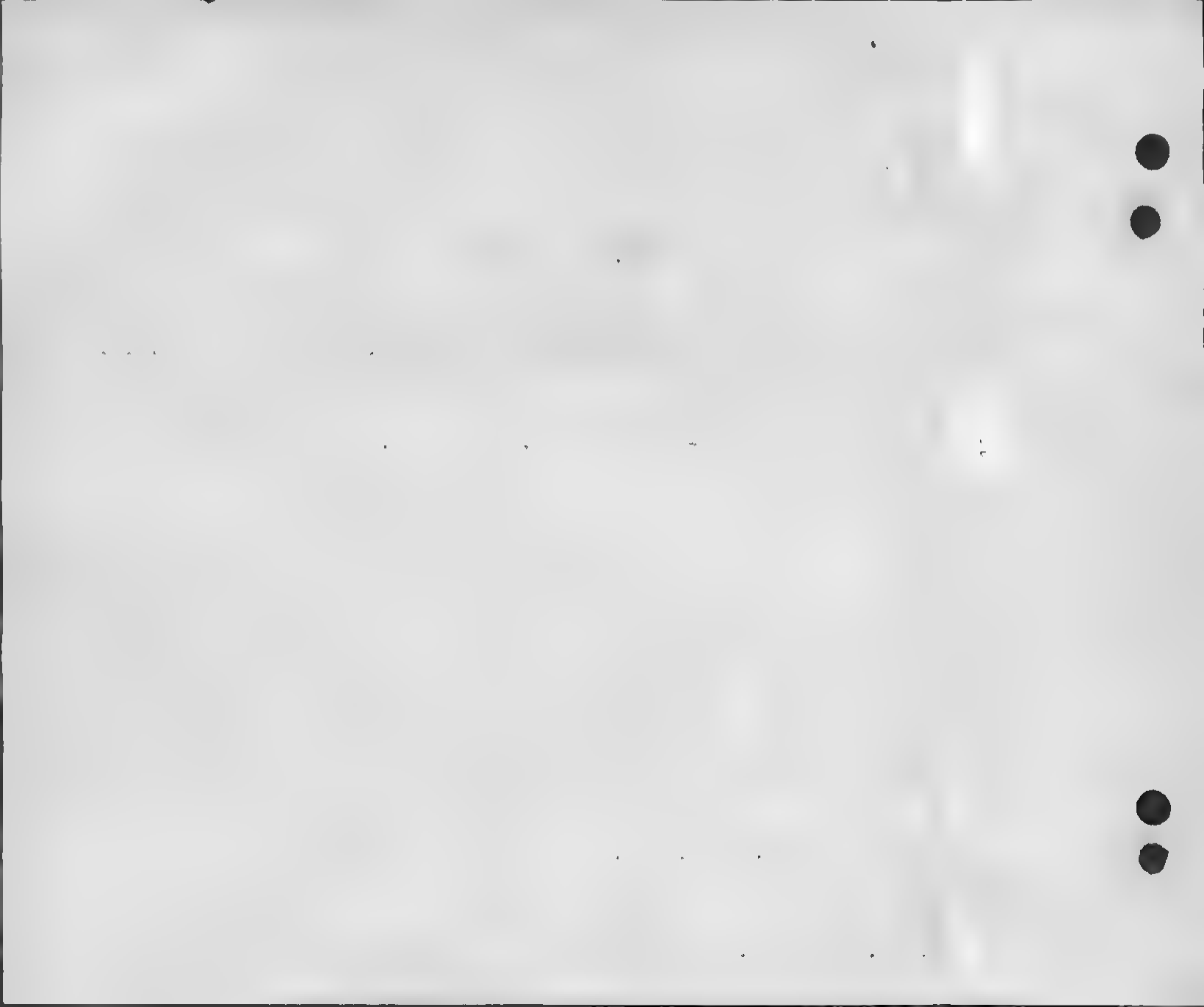
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05182

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution)	
a. COUNTY		a. STATE	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
c. LENGTH OF STAY (in days)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last		Month Day Year	
5. SEX		6. COLOR OR RACE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE in years IF UNDER 1 YEAR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. PLACE, County & State		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter in your own words, if possible, the immediate cause)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE a		b	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		c	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND TONGUE IN PAINT		19. WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACIDENT WAS WORKING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter in Part I, c and Part II, a)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work Not While at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. City or town	
21. I certify that (If in hospital) attended the deceased from 5/28 1961 to 3/28 1961 that (If) (we) saw the deceased alive on 5/28 1961 and that death occurred at 2A M, from the causes and on the date stated above		22a. SIGNATURE	
22b. PHYSICIAN NAME (Type)		22c. ADDRESS	
22d. DATE SIGNED		22e. MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, etc.)	
24. FUNERAL DIRECTOR'S SIGNATURE		24b. ADDRESS	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
DATE		DATE	

VR A15 (4)
15M 9/60





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be re-issued by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5192

CERTIFICATE OF DEATH

Reg. Dist. No. 15183

1 PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u> c. LENGTH OF STAY IN It d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>132 North East Avenue</u>				2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u> d. STREET ADDRESS <u>132 North East Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Robert Wilson Butler</u>				4. DATE OF DEATH Month Day Year <u>May 7 1961</u>			
5 SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8 DATE OF BIRTH <u>3/13/1901</u>	
9 AGE (In years last birthday) <u>60</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Food store</u>		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13 FATHER'S NAME <u>Charles Butler</u>		14 MOTHER'S MAIDEN NAME <u>Harriet Evans</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW-II</u>	
16 SOC. A. SECURITY NO. <u>125-111-111</u>		17 INFORMANT <u>Nellie Butler - 132 North East Ave</u>		18		19	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gastric Hemorrhage</u> DUE TO (b) <u>Gastric Cancer</u> DUE TO (c) <u>Chr. Gastro-enteritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u> <u>37 Days</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1st, 1961</u> to <u>May 7th, 1961</u> that I last saw the deceased alive on <u>May 7th, 1961</u> and that death occurred at <u>5.30 A.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>57 Winters Lane</u> DATE SIGNED <u>May 7th 1961</u>							
ACTUAL SIGNATURE <u>C.F. Maloney</u>				PHYSICIAN'S NAME (Type) <u>C.F. Maloney, M.D.</u>			
22a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b DATE THEREOF <u>5/10/61</u>			
22c NAME OF CEMETERY OR CREMATORY <u>St. Auburn</u>				22d LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
23 FUNERAL DIRECTOR'S SIGNATURE <u>Sullivan Funeral Home</u>				24a REC'D BY REG. STRAR <u>10/11/61</u>			
24b REGISTRAR'S SIGNATURE							

CERTIFICATE OF DEATH

Reg. Dist. No.

05185

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If inst. last Res. before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>CARNEY</u>		c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>CARNEY</u>	
c. LENGTH OF STAY IN 1b <u>10 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2916 E. Joppa Rd</u>		d. STREET ADDRESS <u>2916 E Joppa Rd</u>	
3 NAME OF DECEASED (Type or print) <u>Kate</u> First Middle Last <u>BYRNE</u>		4 DATE OF DEATH <u>MAY 15</u> 19 <u>61</u> Month Day Year	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>MAY 2 1892</u> 89 yrs
9 AGE (In years last birthday) <u>69</u> yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11 BIRTHPLACE (State or foreign country) <u>IRELAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Hugh BYRNE</u>		14 MOTHER'S MAIDEN NAME <u>ESTER DOHERTY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Hugh BYRNE</u> Address <u>SAME</u>	
18 CAUSE OF DEATH [Enter any one cause pertinent for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u>			
DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I attended the deceased from <u>June 8, 1945</u> to <u>May 15, 1961</u> , that I last saw the deceased alive on <u>May 15, 1961</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. J. Alessi M.D.</u>		ADDRESS (Street, city or town, state) <u>6217 Harford Rd</u> DATE SIGNED <u>5, 1961</u>	
PHYSICIAN'S NAME (Type) <u>E. J. Alessi M.D.</u>			
22a. SITE OF CREMATION (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town or county) (State)
<u>BURIAL</u>	<u>MAY 18, 1961</u>	<u>PARKWOOD</u>	<u>BALTO MD</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>C. F. EVANS & Son</u>		ADDRESS <u>8862 Harford Rd</u> 24a. REC'D BY REGISTRAR DATE <u>MAY 15 1961</u>	
		24b. REGISTRAR'S SIGNATURE <u></u>	

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. The attending physician and complete y filled in by the funeral director. After this certificate has been signed by the attending physician and complete y filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



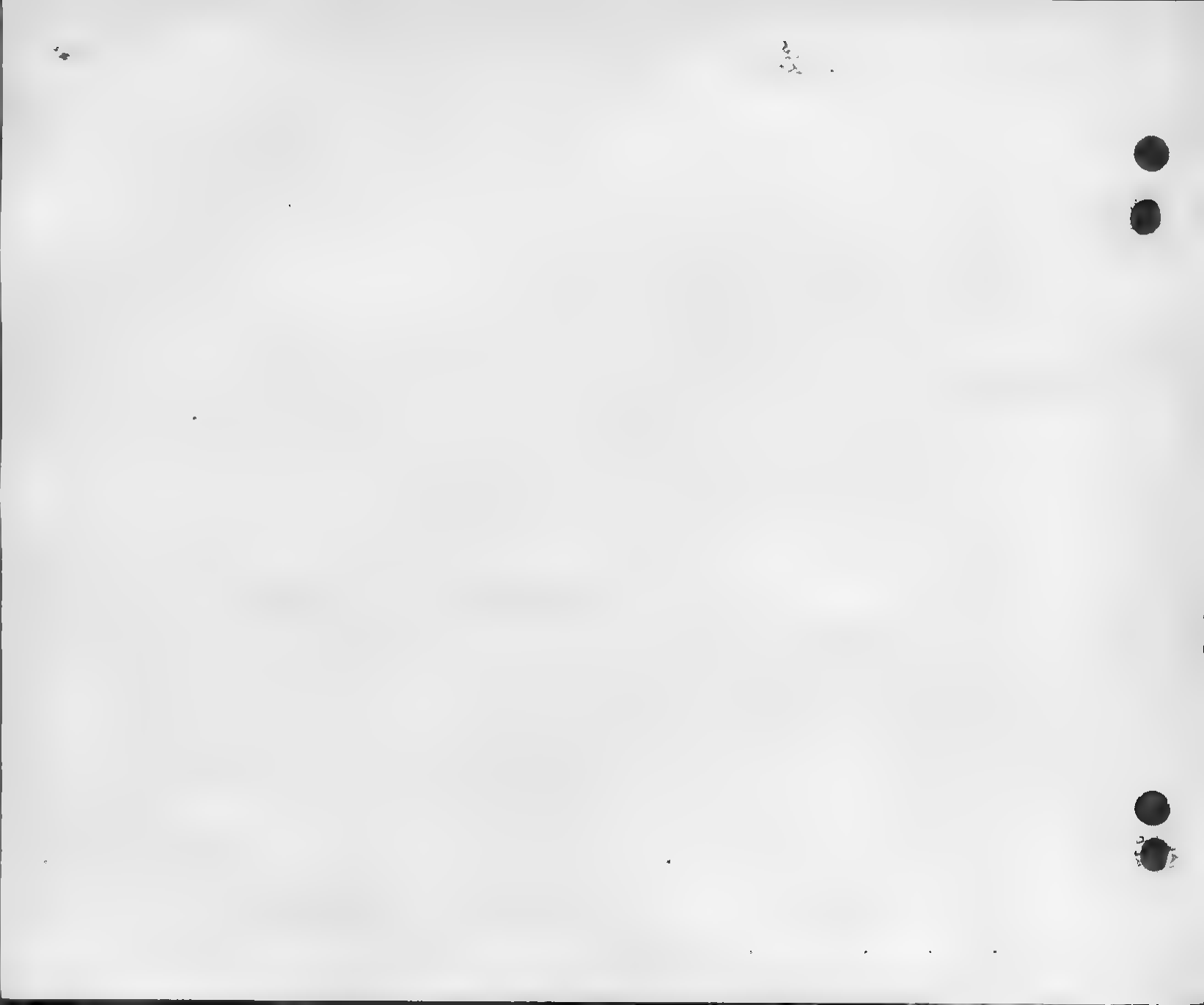


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15187

5195

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission, a. STATE <u>MD</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. LENGTH OF STAY IN 1b <u>3 mos</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Welch Manor</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 10			
f. STREET ADDRESS <u>100 W Univ. Pkwy</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>Cill</u> Last <u>Carlisle</u>				4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1961</u>			
5 SEX <u>F</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>Aug. 22 1877</u>	
9 AGE In years lost birthday) <u>89</u> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Balto. County</u>	
12 CITIZENSHIP OF WHAT COUNTRY? <u>USA</u>							
13 FATHER'S NAME <u>DAVID GRAFTON Carlisle</u>				14. MOTHER'S MAIDEN NAME <u>Frances Cill</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>None</u>		17 INFORMANT <u>Dr. J. B. H. H.</u>		Address <u>George Brown</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>							
DUE TO (b) _____							
DUE TO (c) _____							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I _____							
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 19____				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f (City or town) _____ (County) _____ (State) _____			
21 I certify that (I) (this hospital) attended the deceased from <u>May 16</u> , 19 <u>61</u> to <u>4-14</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at <u>4:45</u> M from the causes and on the date stated above							
22a SIGNATURE <u>Ernest C. Brown, Jr.</u>				22b ADDRESS <u>1101 N. Calvert Street, Baltimore 2, Md.</u>			
22c PHYSICIAN'S NAME (Type) <u>Ernest C. Brown, Jr.</u>				22d ADDRESS <u>1101 N. Calvert Street, Baltimore 2, Md.</u>			
23a BURIAL REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City, town or county)	
<u>BURIAL</u>		<u>5-18-61</u>		<u>Louder Park Cemetery</u>		<u>Baltimore</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>				25a REG'D BY REG. STRAR <u>Wm. Cook, Inc.</u>			
				25b REG. STRAR'S SIGNATURE			



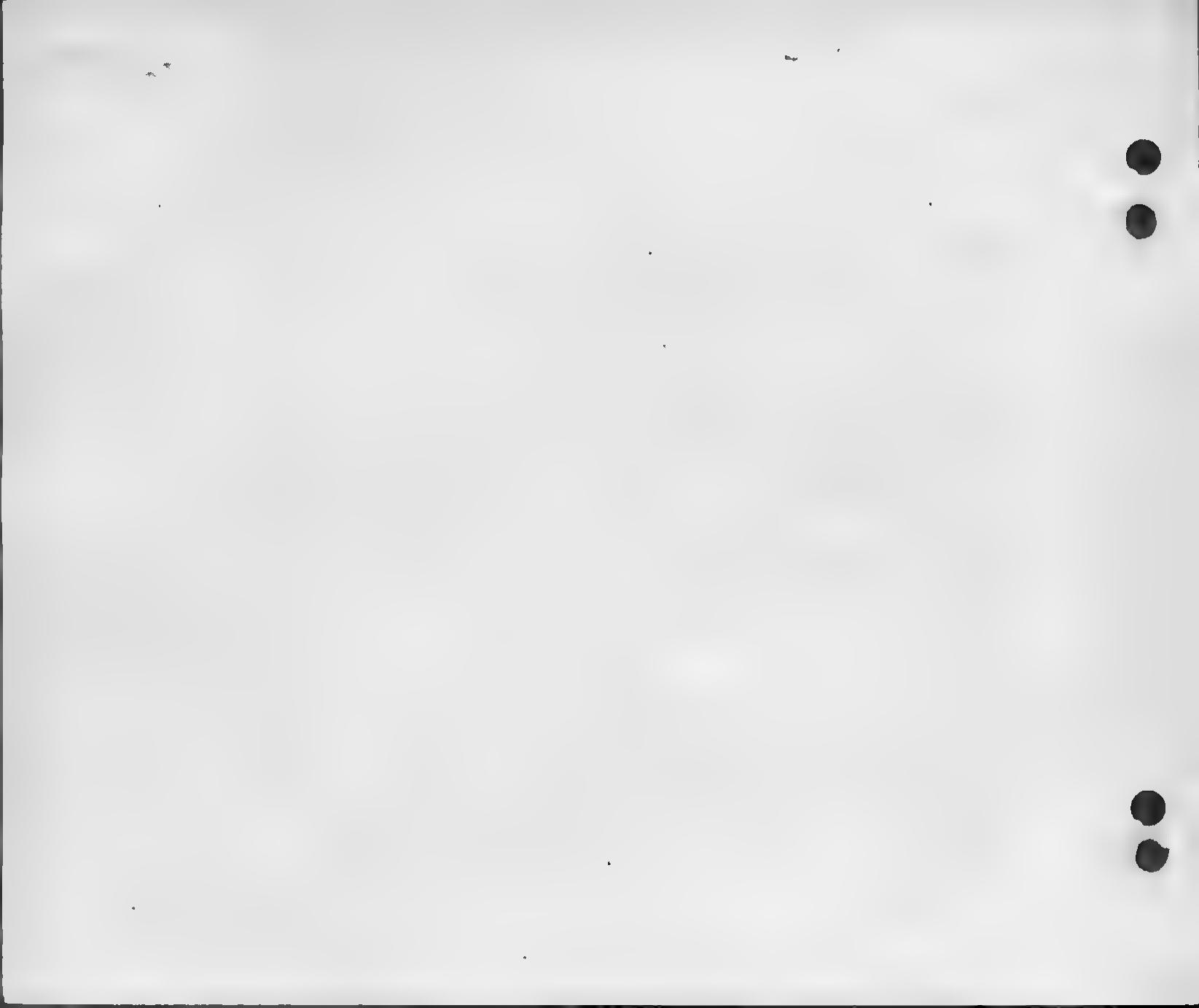
MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18
5196 - em 9811m G207 5/15/61 1WK
CERTIFICATE OF DEATH

Reg. Dist. No. **05188**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson			c. LENGTH OF STAY IN 1b 3 mo				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ludowood Sanatorium Towson 4, Maryland				e. STREET ADDRESS 1526 ORLANDO RD			
3. NAME OF DECEASED (Type or print) First IVAR Middle CARLSON Last CARLSON				4. DATE OF DEATH Month MAY Day 7 Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH MAY 23, 1887				9. AGE (In years last birthday) 74 yrs IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min 0 IF UNDER 24 HRS: Months 0 Days 0 Hours 0 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Contractor				10b. KIND OF BUSINESS OR INDUSTRY OWN BUSINESS			
11. BIRTHPLACE (State or foreign country) NORWAY				12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME KARL CARLSON				14. MOTHER'S MAIDEN NAME ANNA IVERSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give unit or dates of service) NO		16. SOCIAL SECURITY NO. NOTE		17. INFORMANT Address Personal History & Hospital Records, Ludowood Sanatorium			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M, from the causes and on the date stated above. ACTUAL SIGNATURE Wilton B. Kress, M.D. ADDRESS Towson 4, Maryland DATE SIGNED MAY 11 1961 PHYSICIAN'S NAME (Type) Wilton B. Kress, M.D. Towson 4, Maryland							
22a. BURIAL, CREMATION, REMOVAL, (Specify) CREMATION--TRANSIT		22b. DATE THEREOF 5/9/61		22c. NAME OF CEMETERY OR CREMATORY ROSEHILL CEMETERY			
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons		ADDRESS Towson, Md.		24a. REC'D BY REGISTRAR DATE MAY 11 '61			
22d. LOCATION (City, town, or county) LINDEN				(State) NEW JERSEY			
24b. REGISTRAR'S SIGNATURE Charles S. Kress							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05190

1. PLACE OF DEATH
 a. COUNTY **Baltimore**
 b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) **Cockeysville**
 c. LENGTH OF STAY IN 1b
 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Warren Road**

2. USUAL RESIDENCE (Where deceased lived at time of death)
 a. STATE **Maryland**
 b. COUNTY **Baltimore**
 c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) **Cockeysville**
 d. STREET ADDRESS **Warren Road**

3. NAME OF DECEASED
 (Type or print) **ANNA VIRGINIA CASLIN**

4. DATE OF DEATH **May 11, 1961**

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **Oct. 14, 1918**

9. AGE (In years IF UNDER 1 YEAR IF UNDER 2 HRS. last birthday) **42** yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife** 10b. KIND OF BUSINESS OR INDUSTRY **Own Home** 11. BIRTHPLACE (Country & State) **Maryland** 12. CITIZENSHIP OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Albert Hauptman** 14. MOTHER'S MAIDEN NAME **Mary Mahoney**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? **No** 16. SOCIAL SECURITY NO. **220-05-4028** 17. INFORMANT **Family Records** Address

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c)
 PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **Respiratory paralysis**
 (b) **metastatic Carcinoma to Cervical Spine**
 (c) **Carcinoma of Left Breast**

19. INTERVAL BETWEEN ONSET AND DEATH **3 minutes**
6 months
2 1/2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (Mention given in Part I)
Carcinoma metastases to dorsal and lumbar spine leading to paralysis

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury on Part I or Part II of form 18)

20c. TIME OF INJURY Month, Day, Year **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) County (State)

21. I certify that (I) (this hospital) attended the deceased from **March 15, 1957** to **May 10, 1961**, that (I) (we) last saw the deceased alive on **May 10, 1961**, and that death occurred at **12:15 PM**, from the causes and on the date stated above.

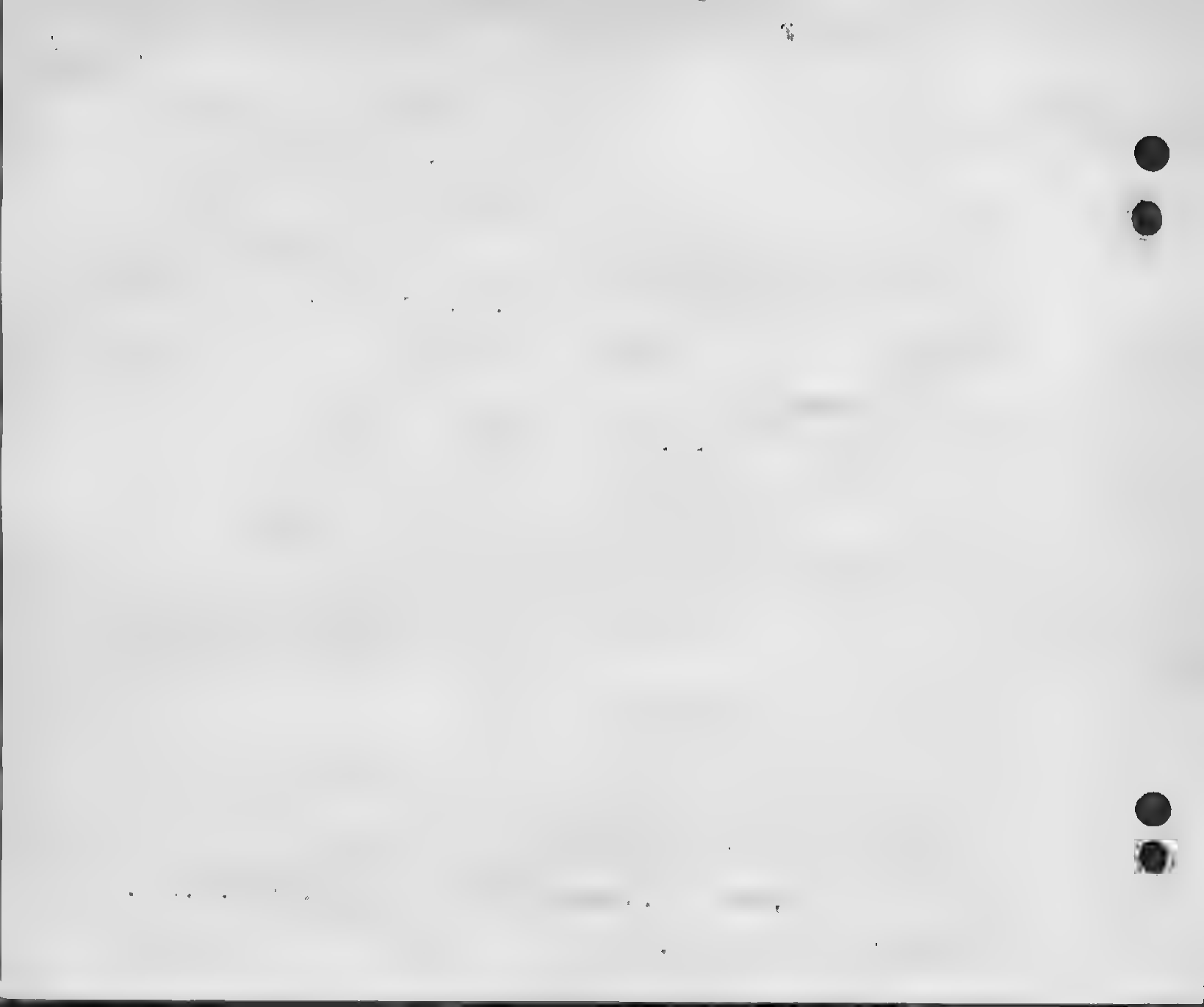
22a. SIGNATURE **Patrick C. Phelan, M.D.** 22b. DATE SIGNED **May 12, 1961**

22c. PHYSICIAN'S NAME (Type) **Patrick C. Phelan, M.D. 840 Pennsylvania Baltimore 1, Md.** 22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **May 13, 1961** 23c. NAME OF CEMETERY OR CREMATORY **St. Joseph's Cemetery** 23d. LOCATION (City, town or county, Md. (State)) **Texas, Balto. Co., Md.**

24. FUNERAL DIRECTOR'S SIGNATURE **John Burns' Sons, Towson, Md.** ADDRESS 25a. REC'D BY REGISTRAR **MAY 15 '61** 25b. REGISTRAR'S SIGNATURE

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and may be retained by the hospital or attending physician.



CERTIFICATE OF DEATH

Reg. Dist. No

05191

1. PLACE OF DEATH a COUNTY 43 Overbrook Road MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE 43 Overbrook Rd. b. COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville Md.	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d STREET ADDRESS 43 Overbrook Road 28	
3. NAME OF DECEASED (Type or print) Catherine Cavanaugh		4. DATE OF DEATH Month May Day 16 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 28/84
9. AGE (in years last birthday) 77 yrs		F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Delilah Arnold		14. MOTHER'S MAIDEN NAME A. Arnold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO ---	
17. INFORMANT Mr. Wm. Cavanaugh, 7818 Rockbourne Rd. 22		Address	
18. CAUSE OF DEATH [Enter only one cause per type for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 8	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus - Insulin Dependent		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1961 to 1961 , that I last saw the deceased alive on 5/16/61 , and that death occurred at 3:22 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED 5/16/61			
ACTUAL SIGNATURE John L. ...		M.D. ...	
PHYSICIAN'S NAME (Type) ...		5/16/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF May 18/61	22c. NAME OF CEMETERY OR CREMATORY Cathedral Cem.	22d. LOCATION (City, town, or county) (State) Soranton Pa.
23. FUNERAL DIRECTOR'S SIGNATURE 2024 Orleans St. 31		24a. REC'D BY REGISTRAR DATE 5/19/61	24b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5200

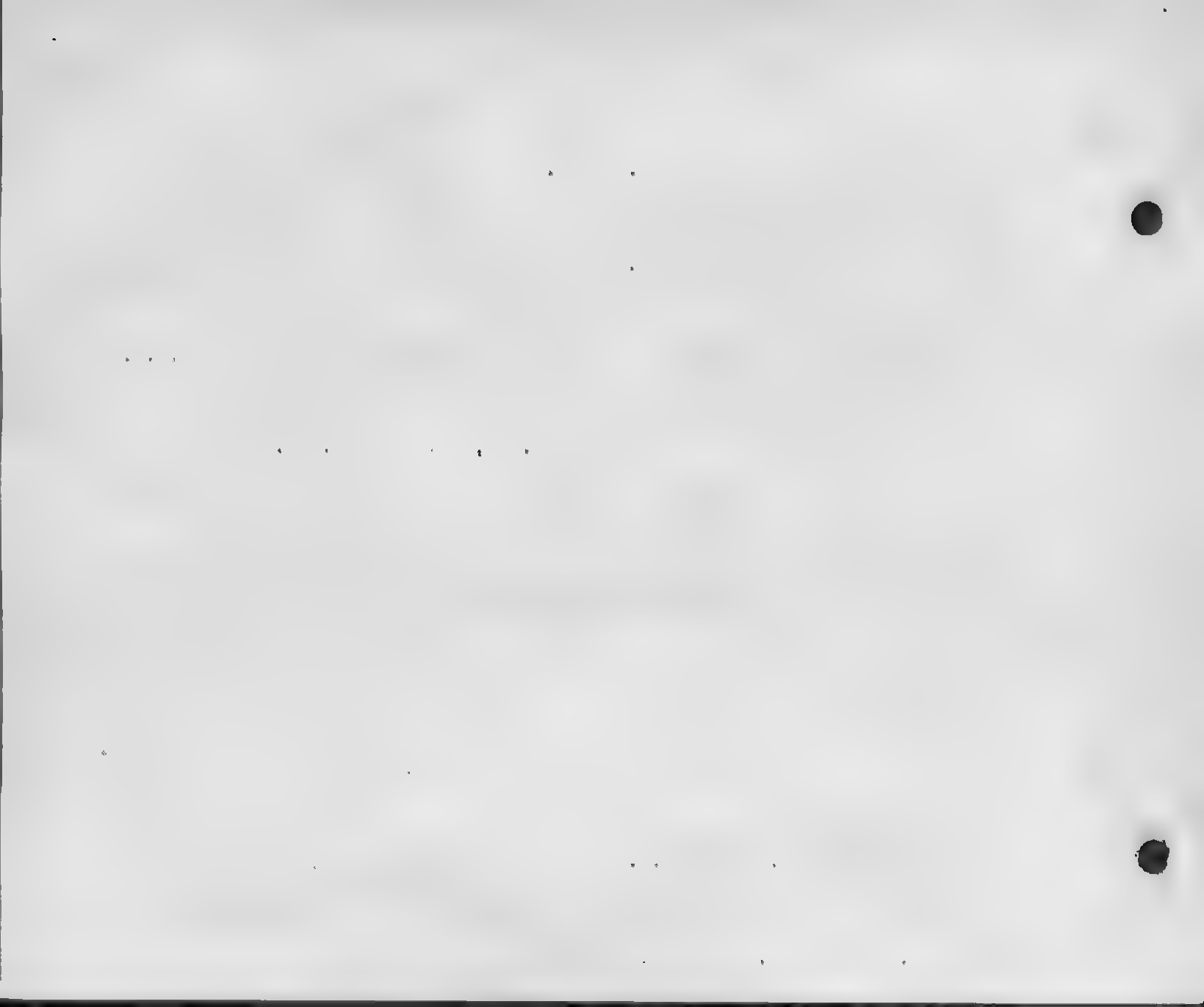
05192

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE Where deceased lived, if institution; Res. of place of birth (mission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 3 Hrs. 20 Min.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Pikesville	
3. NAME OF DECEASED (Type or print) First GEORGE Middle M. Last CECIL		f. STREET ADDRESS 209 Clarendon Avenue	
5. SEX Male	6. CO. OR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4. DATE OF DEATH Month 5 Day 15 Year 1961
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		9. AGE (In years at birthday) 72 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY Concrete		11. BIRTHPLACE Country & State or foreign country Frederick, Maryland	
13. FATHER'S NAME Mortimer Cecil		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give word or dates of service) Yes WW I		14. MOTHER'S MAIDEN NAME Sarah Jane Roelkey	
16. SOCIAL SECURITY NO. 213-26-2331		17. INFORMANT Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO (b) HYPERTENSION DUE TO (c) CEREBRAL ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. UNKNOWN			
19. W. T.opsy PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT OR UNDERLYING OR CONTRIBUTING CAUSE OF DEATH IF EITHER, NOT-IFY MEDICAL EXAMINER. 20b. DESCRIBE HOW INJURY OCCURRED Enter nature of injury in Part I or Part II of Form 18. 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. City (town) County			
21. I certify that (this hospital) attended the deceased from May 15, 1961 to May 15, 1961 that (we) last saw the deceased alive on May 15, 1961 , and that death occurred 4:05 PM from the causes and on the date stated above. 22a. SIGNATURE Arthur T. Faulk M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> DATE 5/15/61 22c. PHYSICIAN'S NAME (Type) ARTHUR T. FAULK, M.D. 22d. ADDRESS VAH, BALTO 18, MD. FORT HOWARD DIVISION			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial 23b. DATE THERE-OF 5-18-1961 23c. NAME OF CEMETERY OR CREMATORY Baltimore National 23d. LOCATION (City, town or county) Baltimore, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Inc. Pikesville, Maryland 25a. REC'D BY REGISTRAR MAY 17 '61 25b. REGISTRAR'S SIGNATURE Arthur T. Faulk			

TO HO L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60





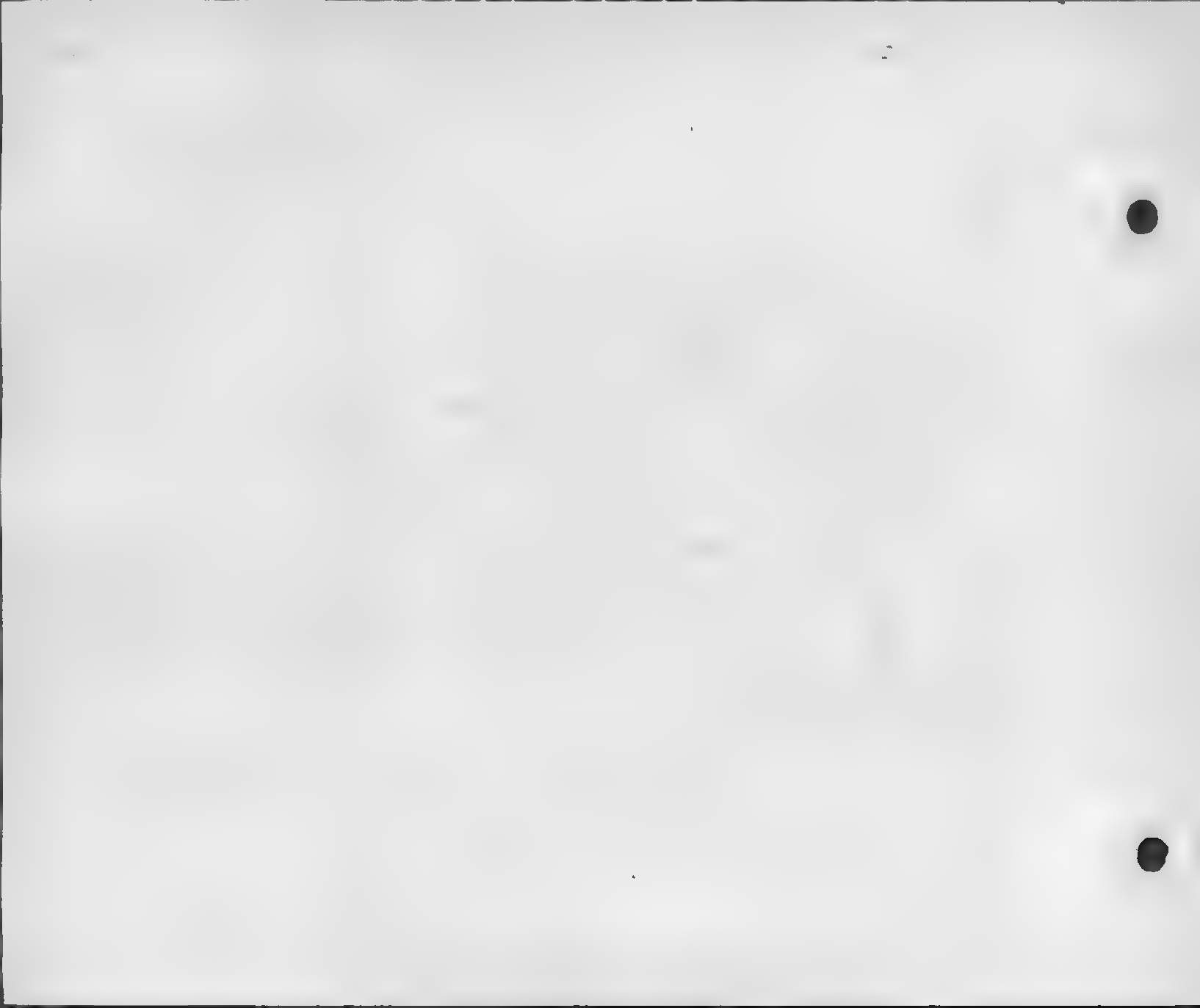
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **15194**

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution Residence before admission) a. STATE MD b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN TB LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7867 HAROLD ROAD				d. STREET ADDRESS 7867 HAROLD ROAD			
3. NAME OF DECEASED (Type or print) First Middle Last JAMES LORAIN CLARK				4. DATE OF DEATH Month Day Year MAY 8 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 28, 1929	9. AGE (in years and birthday) 31 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY STEEL MFGR		11. BIRTHPLACE (State or foreign country) W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. LORAIN CLARK				14. MOTHER'S MAIDEN NAME GLADYS BLEDSOE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO 12-26-0974		17. INFORMANT MRS. J. L. CLARK		Address 2 ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STRANGULATION (HANGING)							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shiny Day from Cellar Ladder					
20c. TIME OF INJURY Month, Day, Year 5-8 1961	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Baltimore	(County) MD	(State) MD		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Melvin B. Davis, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/10/61	
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5/11/61	22c. NAME OF CEMETERY OR CREMATORY BALTO. NAT.		22d. LOCATION (City, town, or county) (State) BALTO, MD.			
23. FUNERAL DIRECTOR'S SIGNATURE Walter Burke Bradley, Dundalk, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please etc.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.
 TO STATE DEPARTMENT OF HEALTH: File pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.



FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If at any time it is necessary, the original of this certificate should be forwarded to the Chief Medical Examiner's Office along with form PMS-5. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) DUNDALK
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 233 BALTIMORE AVE

2. USUAL RESIDENCE (Where deceased lived, if institution, residence, or address)
a. STATE MARYLAND
b. COUNTY BALTIMORE
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DUNDALK
d. STREET ADDRESS 233 BALTIMORE AVE

3. NAME OF DECEASED (Type or print)
First Middle Last
LEOYD G. CLARK

4. DATE OF DEATH
Month Day Year
MAY 10 1961

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED ☐ NEVER MARRIED ☐ DIVORCED ☒ WIDOWED ☐

8. DATE OF BIRTH
Month Day Year
MAY 19 1912

9. AGE in years (Enter birth day, month, and year)
48

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
BAIT TENDER

11. BIRTHPLACE (State or foreign country)
VIRGINIA

12. T. N. D. WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME
J. G. CLARK

14. MOTHER'S MAIDEN NAME
CLIVIA TIPTON

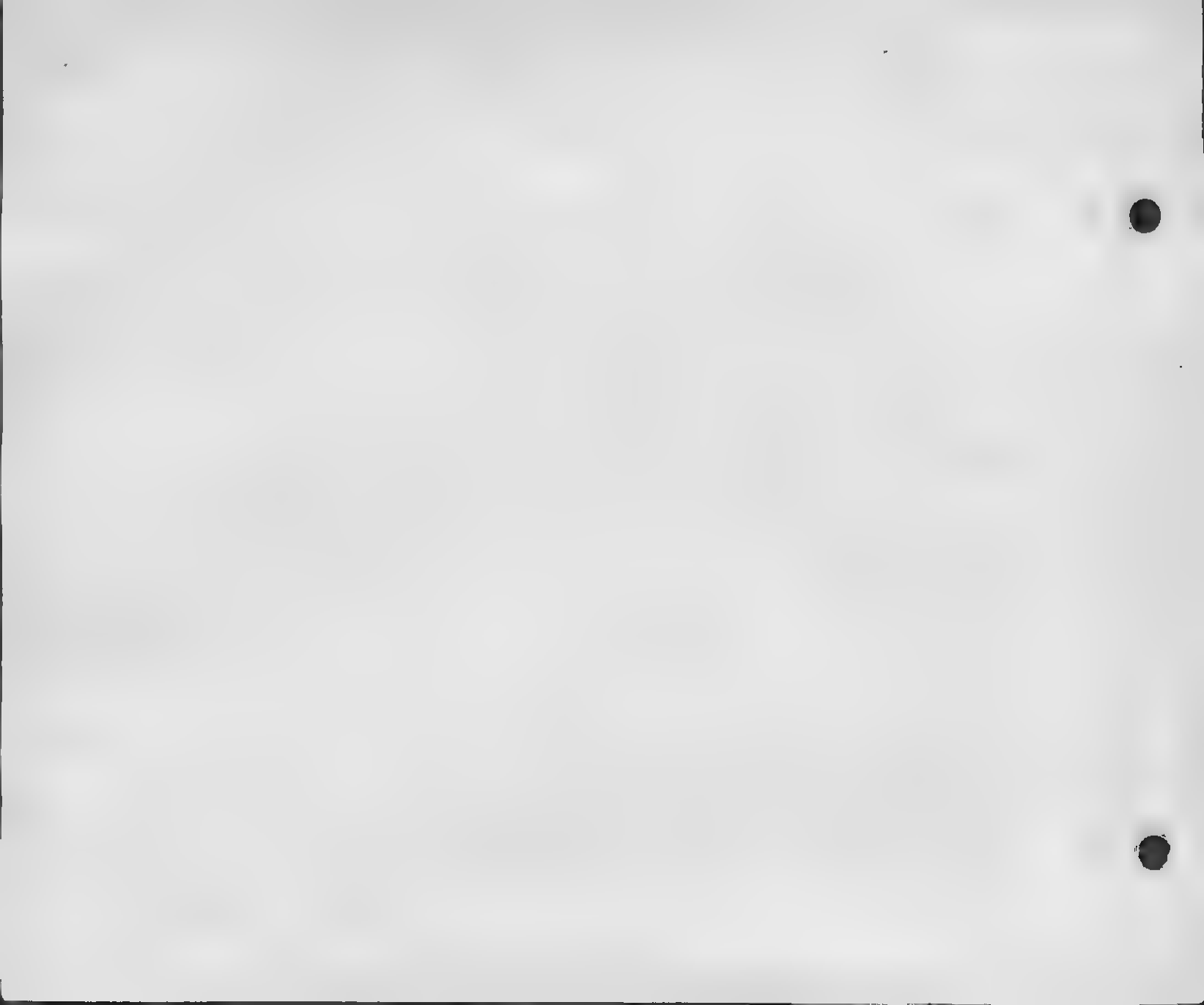
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
NO

16. SOCIAL SECURITY NO.
MD MARGARET FLOWERS 7508 5042 10

17. INFORMANT
MD MARGARET FLOWERS 7508 5042 10

18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION
DUE TO (b) 7-11
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 7-11
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 11/13/1912
12b. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, if item 18)
None
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.
19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home
20f. (City or town) (County)
DUNDALK MD
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒
death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ACTUAL SIGNATURE M B DAVIS
EXAMINER'S NAME M B DAVIS
22a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVED
22b. DATE THEREOF
5/11/61
22c. NAME OF CEMETERY OR CREMATORY
ELLERICH FUNERAL HOME DUNDALK MD
22d. LOCATION (City, town, or county)
DUNDALK MD
24a. REC'D BY REG STRAR
MAY 22 '61
24b. REG STRAR'S NAME
Charles S. Rouse

05195



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05196

1. PLACE OF DEATH
a. COUNTY **BALTIMORE** b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **FORT HOWARD** c. LENGTH OF STAY IN TB **20 DAYS** d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **VETERANS ADMINISTRATION HOSPITAL**

2. USUAL RESIDENCE (Where deceased lived, institution, etc.)
a. STATE **MARYLAND** b. COUNTY **BALTIMORE** c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **345 WYE ROAD** d. STREET ADDRESS **CONDON** e. IS RESIDENCE ON A FARM? ☒ YES ☐ NO

3. NAME OF DECEASED (Type or print) **HENRY G. CONDON** 4. DATE OF DEATH **MAY 3 1961** 5. SEX **MALE** 6. COLOR OR RACE **WHITE** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **JULY 15, 1877** 9. AGE (in years; if under 1 year, last birthday) **83** yrs. 10. U.S. OCCUPATION (Give kind of work done during most of working life, even if retired) **FIREMAN** 11. KIND OF BUSINESS OR INDUSTRY **FIRE DEPT. CITY** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **GEORGE H. CONDON** 14. MOTHER'S MAIDEN NAME **MARY REGAN**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **YES** 16. SOCIAL SECURITY NO. **S A W** 17. INFORMANT **CLINICAL RECORDS VAH BALTO 18 MD FT HOWARD DIV.** Address **UNKNOWN**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE **INFARCTION OF MYOCARDIUM**
DUE TO **ARTERIOSCLERITIC CORONARY THROMBOSIS**
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. **UNKNOWN**
DUE TO **UNKNOWN**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. **CARCINOMA OF PROSTATE WITH METASTASIS TO BONE**

19. WAS AUTOPSY PERFORMED? ☐ YES ☒ NO

20a. TIME OF INJURY (Month, Day, Year) **1961** 20b. INJURY OCCURRED (While at work ☐ Not While at work ☐ 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **VAH BALTO 18, MD, FT HOWARD DIVISION** 20d. CITY OR TOWN **Baltimore** 20e. COUNTY **Baltimore** 20f. STATE **Md.**

21. I certify that **(X)** (this hospital) attended the deceased from **April 13**, 1961 to **May 3**, 1961 that **(X)** (we) last saw the deceased alive on **May 3**, 1961, and that death occurred at **2:00 PM** from the causes and on the date stated above.

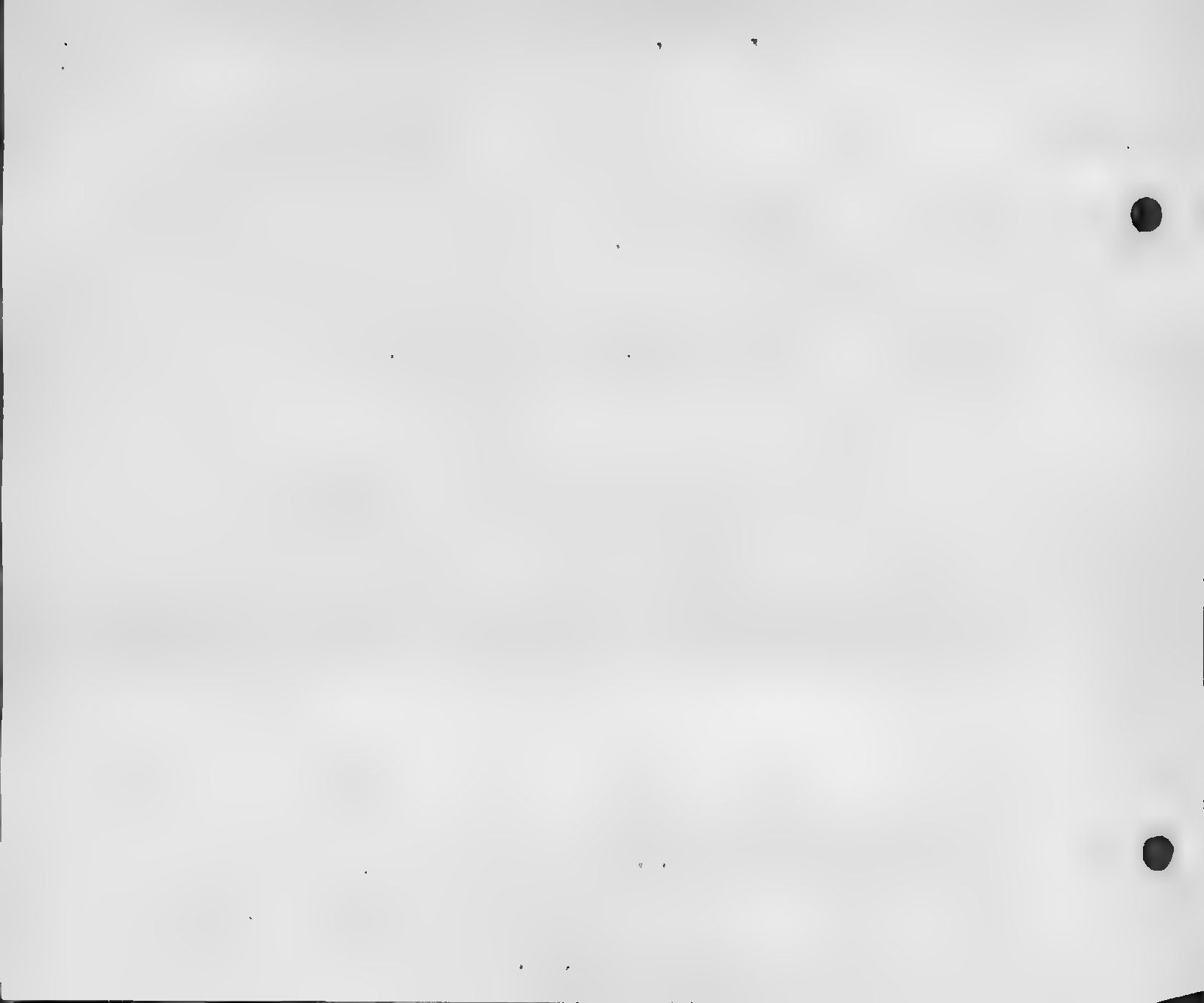
22a. SIGNATURE **Armen Bogosian** 22b. DATE SIGNED **5-3-61**
22c. PHYSICIAN'S NAME (Type) **Armen Bogosian, M.D.** 22d. ADDRESS **VAH BALTO 18, MD, FT HOWARD DIVISION**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **1961** 23c. NAME OF CEMETERY OR CREMATORY **New Cathedral Cemetery** 23d. LOCATION (City, town or county) **Baltimore, Maryland**

24. FUNERAL DIRECTOR'S SIGNATURE **Bruzdzinski Funeral Home** 25a. REC'D BY REGISTRAR **DATE MAY 8 '61** 25b. REGISTRAR'S SIGNATURE **Arthur S. Kraus**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5205

CERTIFICATE OF DEATH

Reg. Dist. No.

05197

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>			
c. LENGTH OF STAY IN TB <u>54 yrs.</u>				d. STREET ADDRESS <u>Old York Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old York Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Rose M. Cooper</u>				4 DATE OF DEATH Month Day Year <u>May 31 1961</u>			
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 2, 1878</u>		9 AGE (in years last birthday) <u>82</u> yrs	10 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <u>Housewife</u>				10b KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11 BIRTHPLACE (State or foreign country) <u>Norrisville, Md.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13 FATHER'S NAME <u>Abraham Trout</u>			
14 MOTHER'S MAIDEN NAME <u>Nancy Jane Morris</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO <u>---</u>				17. INFORMANT Name <u>Mrs. Kathleen Bay, White Hall, Md.</u> Address <u>---</u>			
18 CAUSE OF DEATH [Enter on any one cause per line for (a), (b), and (c)] PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerosis of Heart</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>---</u> (c) <u>---</u> PART 1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) <u>---</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 1 of item 18)			
20c TIME OF INJURY Month Day Year Hour o. m. p. m. <u>19</u>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>	
20f (City or town) <u>---</u>				County <u>---</u>		(State) <u>---</u>	
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>61</u> , to <u>May 31</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>May 30</u> , 19 <u>61</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>---</u> DATE SIGNED <u>---</u>							
ACTUAL SIGNATURE <u>C. M. F. rana</u> M.D.				PHYSICIAN'S NAME (Type) <u>C. M. F. rana</u>			
22a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b DATE THEREOF <u>6-2-61</u>		22c NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d LOCATION (City, town or county) (State) <u>White Hall, Md.</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein, New Freedom, Pa.</u>				24a REC'D BY REGISTRAR DATE <u>May 2 1961</u>		24b REGISTRAR'S SIGNATURE <u>C. J. + S. Traud</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a physician is necessary, he should execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Registrar, Director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05198

1. PLACE OF DEATH
a. COUNTY **Baltimore**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Bowley's Quarters**
c. LENGTH OF STAY IN TB **MARYLAND**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Edward's Road near Bowley's Quarters Rd.**

2. USUAL RESIDENCE (where deceased lived, if institution, give name)
a. STATE **Maryland**
b. COUNTY **Baltimore**
c. CITY OR TOWN (if outside corporate limits, write RURAL) **Bowley's Quarters**
d. STREET ADDRESS **Edward's Rd. Near Bowley's Quarters Rd.**

3. NAME OF DECEASED
First Middle Last
WALTER BURTON COPENSPIRE

4. DATE OF DEATH
Month Day Year
May 28, 1961

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH
Month Day Year (last birthday) **Feb. 4, 1888**

9. PLACE OF BIRTH (State or foreign country)
USA

10. KIND OF BUSINESS OR INDUSTRY
Civil Service-retired Disposal Engineer Maryland

11. MOTHER'S MARRIAGE NAME
Unknown-deceased

12. SOCIAL SECURITY NO. **Unknown-deceased**

13. CAUSE OF DEATH (Enter only one cause, but you may list more than one)
PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **A-S-C-V-DISEASE**
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
DUE TO (d) _____

14. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury and place where it occurred)
None

15. TIME OF INJURY (Month Day Year) (Hour Minute P.m.)
19

16. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
et work

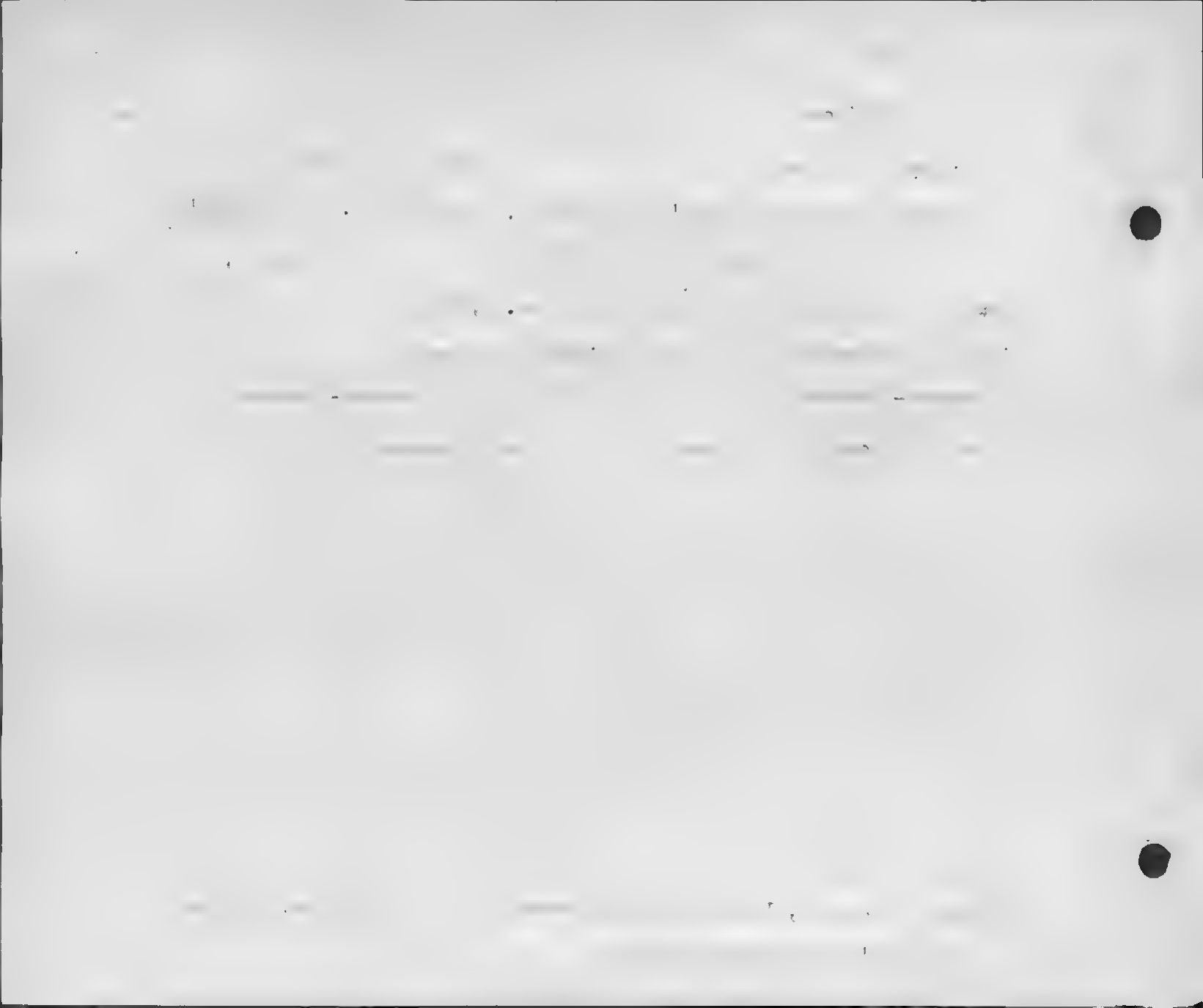
17. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ is my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

18. ACTUAL SIGNATURE **M.B. Davis**
EXAMINER'S NAME **M.B. DAVIS M.D.**

19. BURIAL (CREMATION) 20. DATE THEREOF **June 1, 1961** 21. NAME OF CEMETERY OR CREMATORY **Parkwood Cemetery**
22. LOCATION (city, town, county) **Parkville, Maryland**

23. FUNERAL DIRECTOR **John Burns' Sons, Towson, Maryland**

24. REC'D BY REGISTRAR **JUN 1 '61** 25. REGISTRAR'S SIGNATURE **Charles P. King**



TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

1

M

MEDICAL CERTIFICATION

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Reisterstown

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Hanover Road

2. USUAL RESIDENCE (Where deceased lived immediately before death)

a. STATE

MD.

b. COUNTY

Harrell

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hampstead

d. STREET ADDRESS

ON A FARM?
YES ☐ NO ☐

3. NAME OF DECEASED
(Type or print)

Arthur

C.

Cullison

4. DATE OF DEATH

May

6,

1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

Dec. 28, 1906

9. AGE (yrs.)

74

10. IF UNDER 1 YEAR

11. MONTHS

12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Farmer

13. KIND OF BUSINESS OR INDUSTRY

14. BIRTHPLACE (State or foreign)

Maryland

15. WHEN

16. FATHER'S NAME

Charles W. Cullison

17. MOTHER'S MAIDEN NAME

Catherine Armocost

18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown)

19. SOCIAL SECURITY NO.

Mrs. Raymond Hann

Address

Upperco, Md.

20. CAUSE OF DEATH (Enter only one cause per line for a, b, and c)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Compound fracture left leg, fracture L. thigh,
Compound fracture R. leg, Crushed chest, Fractured
L. arm, Fractured neck, Internal Hemorrhage.

DUE TO

Condition or any which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(c)

21. OTHER NEARLY CAUSES CONTRIBUTE TO DEATH? (If not related to the terminal disease "ONSET" of death)

none

22. EXTERNAL CAUSE AS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

23. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II or item 18)

pedestrian struck by auto

24. TIME OF INJURY (Month, Day, Year)

2:45xxx 5-6-61

25. INJURY OCCURRED

While at work ☐ Not While at work ☒

26. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

highway

27. (City or town)

Reisterstown, Balto., Md.

28. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquest ☒ death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

D. D. Caples

CHIEF MEDICAL EXAMINER

29. ASSISTANT MEDICAL EXAMINER

EXAMINER'S
NAME (Type)

D. D. Caples, M. D., 6 Hanover Rd., Reisterstown, Md.

DEPUTY MEDICAL EXAMINER

DATE SIGNED

5-8-61

30. BURIAL CREMATION
REMOVAL (Specify)

Burial

31. DATE THEREOF

May 8, 1961

32. NAME OF CEMETERY OR CREMATORY

St. Paul Cemetery

33. LOCATION (City, town, or country)

Upperco, Md.

34. FUNERAL DIRECTOR

ADDRESS

Tipton-Wline Funeral Home Hampstead, Md.

35. REC'D BY REGISTRAR

MAY 9 '61

36. REGISTRAR'S SIGNATURE

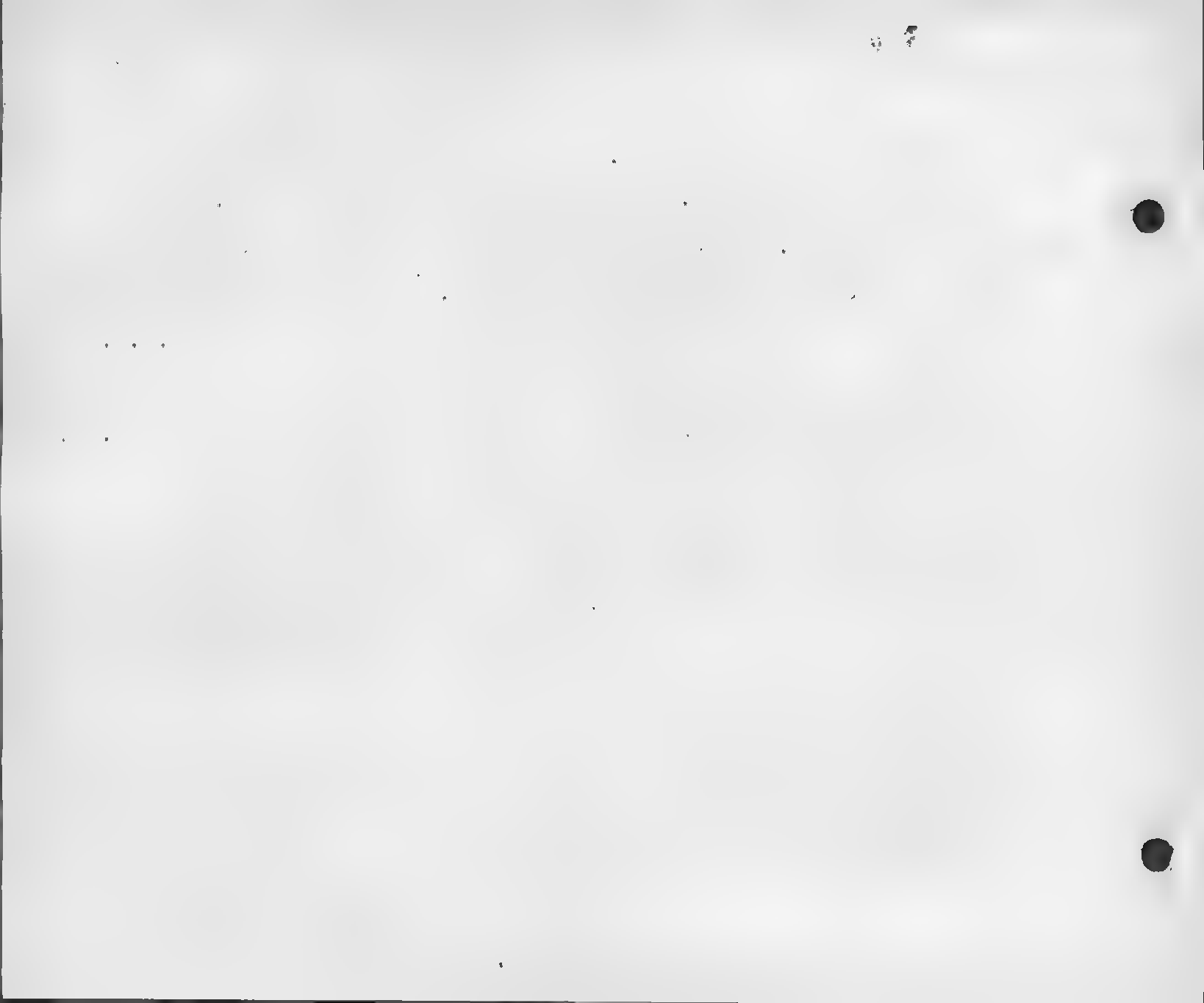
Arthur S. Hann



1
M

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived) If institution: Residence before death a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b 5 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1317 Sulphur Spring Rd.		d. STREET ADDRESS 1317 Sulphur Spring Rd.	
3 NAME OF DECEASED (Type or print) Conrad E. Denhardt		4 DATE OF DEATH May 2, 1961	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 2, 1876
9 AGE In years 85 last birthday		10 IF UNDER 1 YEAR: Months 1 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer		10b. KIND OF BUSINESS OR INDUSTRY Straw Hat	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Unknown		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO. 218-10-2061	
17 INFORMANT Frieda Denhardt		Address 1317 Sulphur Sp. Rd.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1201 DUE TO Arterio Sclerosis Cardio-Vascular			
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial DUE TO (c) Infarction			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sp. Infarction			
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20a. TIME OF INJURY Month, Day, Year 19 Hour a.m. 1 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 , and that death occurred at M. from the causes and on the date stated above.			
22a. SIGNATURE M. Pauli		22b. DATE SIGNED May 2, 1961	
22c. PHYSICIAN'S NAME (Type) M. Pauli		22d. ADDRESS 20	
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		23b. DATE THEREOF 5/6/61	
23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ambrose, Inc.		25a. REC'D BY REGISTRAR DATE MAY 5	
ADDRESS 1328 Sulphur Spring Rd.		25b. REGISTRAR'S SIGNATURE 6/2/61	

I



may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5205

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

05201

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived first 1 year before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>	
c. LENGTH OF STAY IN 1b <u>9 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home 231 Deep Dale Drive</u>		d. STREET ADDRESS <u>231 Deep Dale Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Donald DeVesty</u>		4. DATE OF DEATH Month <u>5</u> Day <u>7</u> Year <u>1961</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-6-1918</u>
9 AGE (in years lost birthday) <u>43</u> yrs		10 UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Agent</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11 BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Charles Edward DeVesty</u>		14 MOTHER'S MAIDEN NAME <u>Minnie J. Warden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16 SOCIAL SECURITY NO (If yes, give war or dates of service) <u>78-01-2343</u>	
17. INFORMANT <u>Anita DeVesty</u>		Address <u>231 Deep Dale Dr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO (b) <u>CORONARY ARTERIOSCLEROSIS</u> DUE TO (c) <u>CHOLELITHIASIS</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>CHOLELITHIASIS</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>3 MINS.</u> <u>1 MOS.</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (1) (this hospital) attended the deceased from <u>21 APRIL 1961</u> to <u>7 MAY 1961</u> that (2) (we) last saw the deceased alive on <u>5/3/61</u> and that death occurred <u>4:45 PM</u> on the causes and on the date stated above			
22a SIGNATURE <u>Donald O. Wood, M.D.</u>		22b ADDRESS <u>TIMONIUM, MD</u>	
22c PHYSICIAN'S NAME (Type) <u>DONALD O. WOOD, M.D.</u>		22d ADDRESS <u>TIMONIUM, MD</u>	
23a BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>5-11-61</u>	
23c NAME OF CEMETERY OR CREMATORY <u>George Wash. Memorial</u>		23d LOCATION (City, town, or county) <u>Parvus N.J.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Brooks Funeral Service Towson 4, Maryland</u>		25a REC'D BY REGISTRAR <u>MAY 9 '61</u>	
25b REGISTRAR'S SIGNATURE <u>C. L. L. L.</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

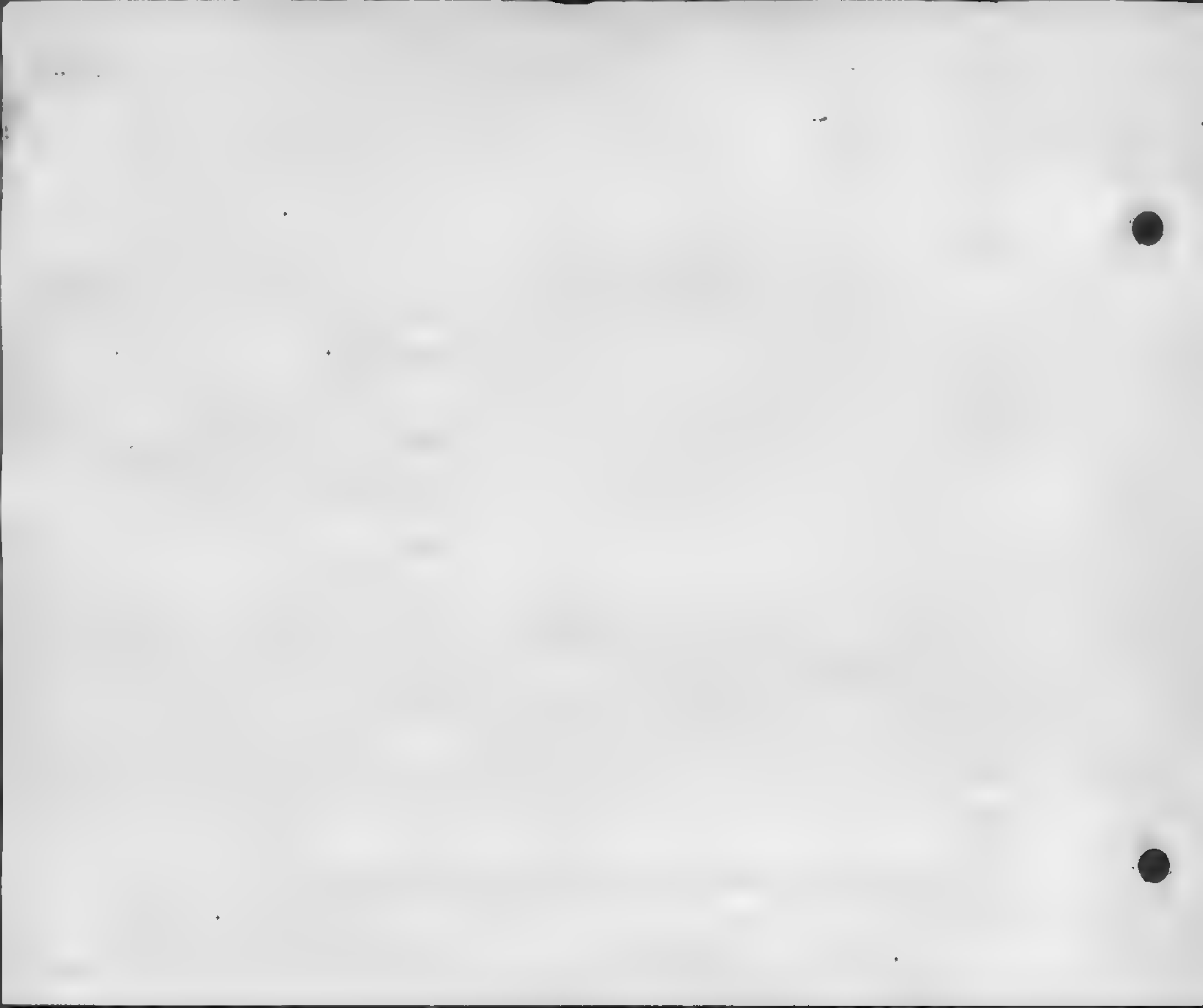
5211

CERTIFICATE OF DEATH

WK

Reg. Dist. No. 05203

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md b. COUNTY Baltimore Co	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Rural Baltimore 29	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5417 Masfield Rd		d. STREET ADDRESS 5417 Masfield Rd. <input type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle DILL Last		4. DATE OF DEATH Month May Day 7 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/24/1876
9. AGE (In years last birthday) 85 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Walters		14. MOTHER'S MAIDEN NAME ? Horst	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 219-20-8812	
17. INFORMANT Mary Wilhelm Address 5417 Masfield Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C-V disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 4 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) CLACSTOMY TO RELIEVE PARTIAL OBSTRUCTION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/22 , 19 59 , to 5/7 , 19 61 , that I last saw the deceased alive on 5/7 , 19 61 , and that death occurred at 9:30 P.M., from the causes and on the date stated above			
ACTUAL SIGNATURE Paul R. Ziegler		ADDRESS (Street, city or town, state) 3723 EDMONDSON AVE. E DATE SIGNED	
PHYSICIAN'S NAME (Type) PAL R. ZIEGLER		BALTC 29, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/10/61	22c. NAME OF CEMETERY OR CREMATORY Western Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE John M. Weber ADDRESS 5311 Edmondson Ave		24a. REC'D BY REGISTRAR DATE 5/10/61	24b. REGISTRAR'S SIGNATURE William E. ...



may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5212

05204

1 PLACE OF DEATH a COUNTY <u>MARYLAND</u> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2012 MB</u> c LENGTH OF STAY IN 1b <u>20 1/2 mo</u> d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2012 MB</u>				2 USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a STATE <u>MD</u> b COUNTY <u>PR</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHERRY</u> d STREET ADDRESS <u>2012 MB</u> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>JOHN</u> Middle <u>JOHN</u> Last <u>JOHN</u>		4 DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>1961</u>		5 SEX <u>MALE</u>		6 COLOR OR RACE <u>WHITE</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8 DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>11-14-20</u>		9 AGE (in years lost birthday) <u>41</u> 10 UNDER 1 YEAR IF UNDER 24 HRS Months <u>11</u> Days <u>14</u> Hours <u>20</u> Min <u>00</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u> 10b KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u> 11 BIRTHPLACE (State or foreign country) <u>WASHINGTON DC</u> 12 CITIZEN OF WHAT COUNTRY? <u>US</u>				13 FATHER'S NAME <u>JOHN GEORGE DOWNEY</u> 14 MOTHER'S MAIDEN NAME <u>CAROLINE E TRAUTMAN</u>							
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO <u>NONE</u>		17 INFORMANT <u>Hospital Records, etc.</u> Address <u>1370 N State Street</u>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>FALL FROM 20' BUILDING</u> DUE TO (b) <u>CONDITIONS, FONY WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST</u> DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>104</u>											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19 WAS A POSTMORTEM PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>20' BUILDING</u>							
20c TIME OF INJURY Month <u>11</u> Day <u>14</u> Year <u>1961</u> Hour <u>5</u> a.m. <u>PM</u>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>20' BUILDING</u> (County) <u>PR</u> (State) <u>MD</u>					
21 I certify that (I) (this hospital) attended the deceased from <u>11-14-1961</u> to <u>5 d</u> 1961 that (I) (we) last saw the deceased alive on <u>5-7-1961</u> and that death occurred at <u>3:30 M</u> from the causes and on the date stated above 22a SIGNATURE <u>[Signature]</u> 22b DATE <u>11-14-61</u> 22c PHYSICIAN'S NAME (Type) <u>JOHN</u> 22d ADDRESS <u>1370 N State Street</u> M.D. <input type="checkbox"/> ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>											
23a RURAL CREMATION <input type="checkbox"/> 23b DATE THEREOF <u>11-14-61</u> RFA 001 (Spec. fr.)				23c NAME OF CEMETERY OR CREMATORY <u>1370 N State Street</u>		23d LOCATION (City, town or county) <u>PR</u> (State) <u>MD</u>					
24 FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>1370 N State Street</u>				25a REC'D BY REGISTRAR <u>[Signature]</u> 25b REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>MAY 10 1961</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5213

05205

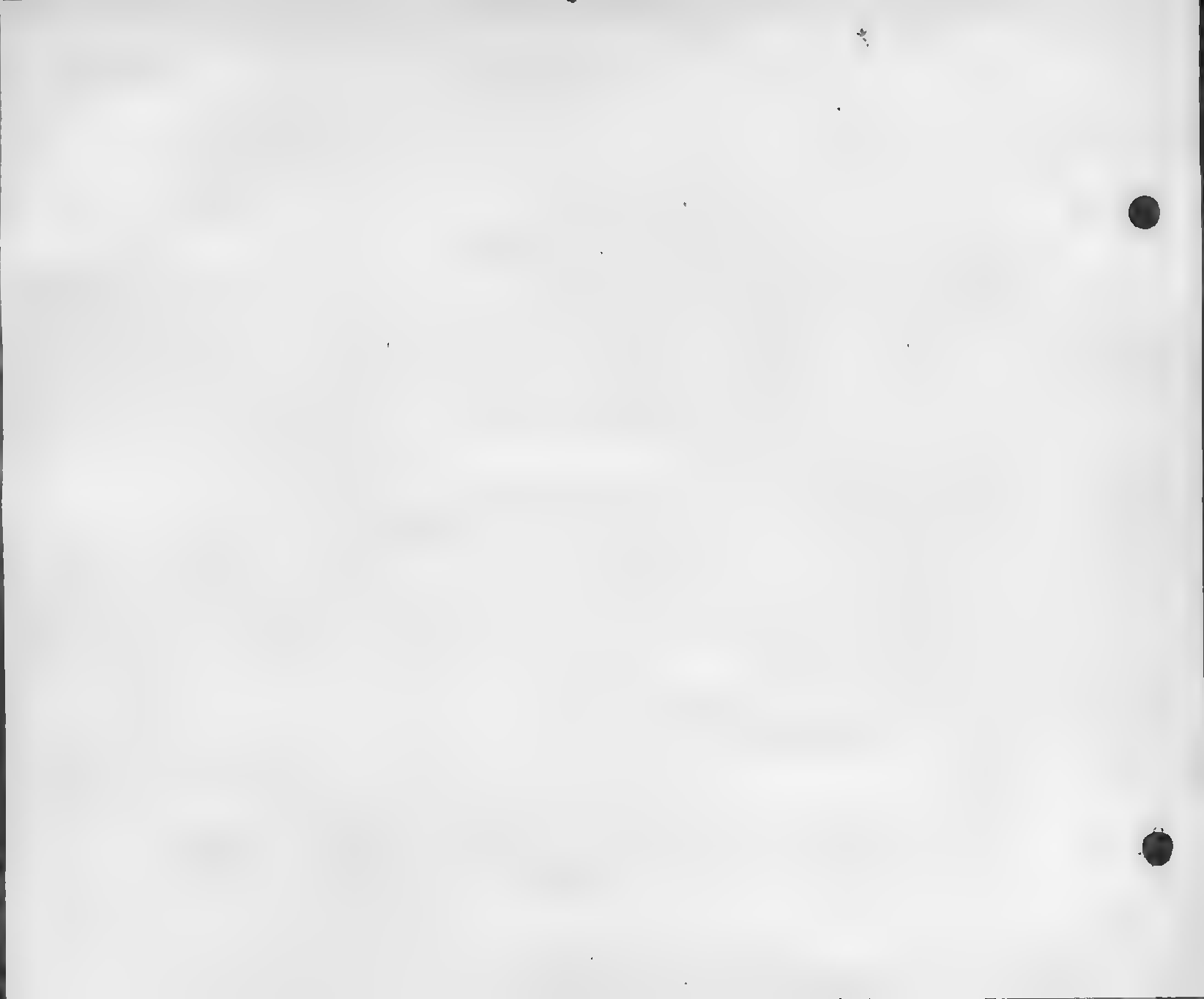
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived if not at residence) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If out of county, write RURAL and give nearest town) Middle River		c. LENGTH OF STAY IN CITY OR TOWN If outside of Baltimore, write RURAL and give nearest town Middleriver	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 209 Riverthorn Road		e. STREET ADDRESS 209 Riverthorn Rd.	
3. NAME OF DECEASED Type - print JOHN LEE DUGGAN		4. DATE OF DEATH Month May Day 5 Year 1961	
5. SEX male RACE white MARRIED <input checked="" type="checkbox"/> NEVER MARRIED		6. AGE In years 54 Sex M	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) millright-maintenance Martin Co.		10b. KIND OF BUSINESS OR INDUSTRY Balto. Md.	
11. BIRTHPLACE (County, State, or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? unknown	
13. FATHER'S NAME John Duggan		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. 17. INFORMANT Helen Belsky Duggan, wife, above	
18. CAUSE OF DEATH (Enter only one cause, but one for a, b, and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) IX DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis (c), stating the underlying cause last. Regional enteritis		INTERVIEW BETWEEN UNSET AND DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I) Regional enteritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of cause of death)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. Minute 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town	
21. I certify that (I) (this hospital) attended the deceased from April 20, 1961 to 5-5-1961 that (I) (we) last saw the deceased alive on April 28, 1961 and that death occurred at 10:30 PM , from the causes and on the date stated above			
22a. SIGNATURE Helen Belsky Duggan		22b. ADDRESS 5/6/61	
22c. PHYSICIAN'S NAME (Type) Charles E. Schimunek		22d. ADDRESS Funeral Home	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/9/61	
23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION (City, town, or county) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek		25a. REC'D BY REGISTRAR May 9 '61	
25b. REGISTRAR'S SIGNATURE Charles E. Schimunek		25c. DATE May 9 '61	



5214
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

05206

1 PLACE OF DEATH a COUNTY Balto. MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE Maryland b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5515 Dolores Ave.		d. STREET ADDRESS 5515 Dolores Avenue	
3. NAME OF DECEASED (Type or print) First Katherine Middle B. Last Durken		4. DATE OF DEATH Month May Day 25 Year 1961	
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE 5/29/88 W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 AGE (in years last birthday) 72 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Md.		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Karl Zephir		14 MOTHER'S MAIDEN NAME Dorothea Zang	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO	
17 INFORMANT Family - Same		Address	
18 CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Arteriosclerosis DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Dis. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from August 19, 1958 to May 19, 1961 that (I) (we) last saw the deceased alive on January 19, 1961 , and that death occurred at 8 P.M. from the causes and on the date stated above.			
22a SIGNATURE Alvin A. Jones, M.D.		22b DATE SIGNED 5/26/61	
22c PHYSICIAN'S NAME (Type) Alvin A. Jones, M.D.		22d ADDRESS 1039 Hill Road, Baltimore	
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF 5/29/61	
23c NAME OF CEMETERY OR CREMATORY Cedar Hill		23d LOCATION (City, town or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Fort Ave. #30		25a. REC'D BY REGISTRAR DATE 5/29/61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur E. Jones	



CERTIFICATE OF DEATH

Reg. Dist. No

05207

5215

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Royal Rosedale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Royal Rosedale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8227 Philadelphia Rd.</u>		d. STREET ADDRESS <u>8227 Philadelphia Rd.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Luanne Bliss Duvall</u>		4 DATE OF DEATH Month Day Year <u>7 26 1961</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept. 27, 1883</u>
9 AGE (in years last birthday) <u>77</u>		10 AGE (in years) IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Upperco, Baltimore, Maryland</u>		12 CITIZEN OF WHAT COUNTRY	
13 FATHER'S NAME <u>John L. Hundertmark</u>		14 MOTHER'S M.A.DEN NAME <u>Martha V. Borning</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No) <u>No</u>		16 SOCIAL SECURITY NO. <u>None</u>	
17 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>332X</u> DUE TO <u>Heart Failure</u> Conditions if any which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Chronic Arteriosclerosis</u> (c) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>None</u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office b'dg., etc.)		20f (City or town) (County) (State)	
21. I certify that attended the deceased from <u>1955</u> to <u>1961</u> , that I last saw the deceased alive on <u>4/21</u> , 19 <u>61</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Emmett P. Davis</u> M.D.		DATE SIGNED <u>May 27 1961</u>	
PHYSICIAN'S NAME (Type) <u>Emmett P. Davis, M.D.</u>		5317 Belair Road, Baltimore 6, Maryland	
22a BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	22b DATE THEREOF <u>5-29-61</u>	22c NAME OF CEMETERY OR CREMATORY <u>Union Church Cemetery</u>	22d LOCATION (City, town, or county) (State) <u>Black Rock, Upperco, Maryland</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. Crach</u> ADDRESS <u>1211 Chasard Ave.</u>		24a REC'D BY REGISTRAR DATE <u>MAY 31 '61</u>	24b REGISTRAR'S SIGNATURE <u>Charles S. Huns</u>

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5216

05208

1. PLACE OF DEATH
a. COUNTY **Baltimore**
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Towson**
c. LENGTH OF STAY IN 1b **MARYLAND**
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **419 Georgia Court**

2. USUAL RESIDENCE (Where deceased lived, if not a resident, give address of nearest relative)
a. STATE **Maryland**
b. COUNTY **Baltimore**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Towson**
d. STREET ADDRESS **419 Georgia Court**

3. NAME OF DECEASED (Type or print)
First **ALICE** Middle **BOURNE** Last **EATON**

4. DATE OF DEATH
Month **May** Day **8** Year **1961**

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH
Last birthday: **April 7, 1878** Months **83** Years **83**

9. AGE, in years: **83** FURNISHED YEAR IF UNDER 24 HRS. last birthday: Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife** 10b. KIND OF BUSINESS OR INDUSTRY **Own Home** 11. BIRTHPLACE (Country & State) **Kentucky** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **J. C. Bourne** 14. MOTHER'S MAIDEN NAME **Unknown**

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) **No** 16. SOCIAL SECURITY NO. **None** 17. INFORMANT **Family Records**

18. CAUSE OF DEATH (Enter only one cause, unless otherwise indicated)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **CONGESTIVE HEART FAILURE**
DUE TO **ARTERIOSCLEROTIC HEART DISEASE WITH AORTIC INSUFFICIENCY**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: **8-10 YRS**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: **INTERVAL BETWEEN ONSET OF DEATH 2 WKS**

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY (Month, Day, Year) **19** 20d. INJURY OCCURRED (While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) **206 W. Penna. Ave., Towson 4, Md.**

21. I certify that (i) (this hospital) attended the deceased from **4/5/55**, 19 to **5/8/61**, 19, that (i) (we) last saw the deceased alive on **5/5/61**, 19, and that death occurred at **4A** AM, from the causes and on the date stated above.

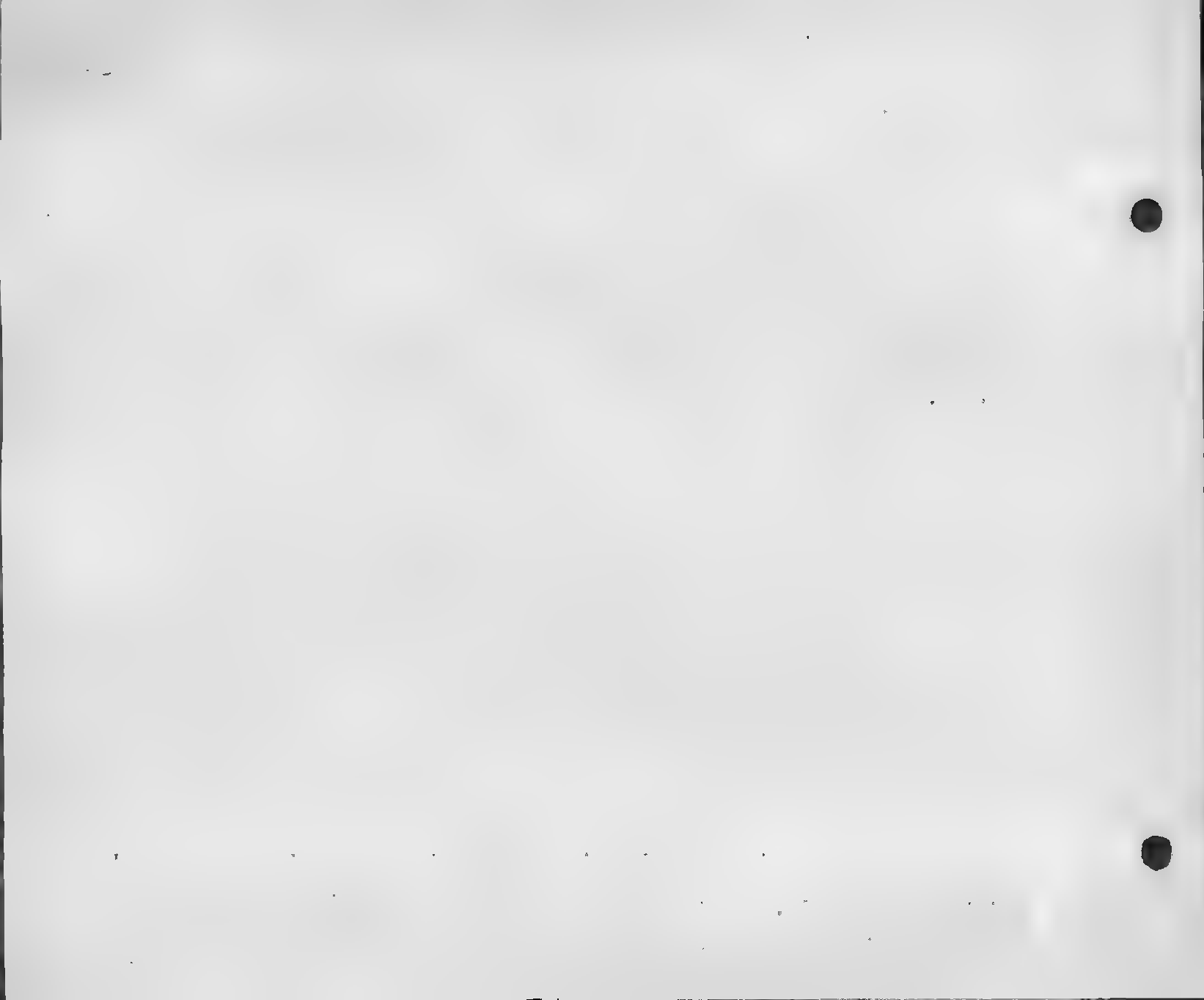
22a. SIGNATURE **J. C. Siwinski** 22b. DATE SIGNED **5/9/61**
22c. PHYSICIAN'S NAME (Type) **Thaddeus C. Siwinski, M.D.** 22d. ADDRESS **206 W. Penna. Ave., Towson 4, Md.**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial/Transit May 10, 1961 Cave Hills' Semetary** 23b. DATE THEREOF **May 10, 1961** 23c. NAME OF CEMETERY OR CREMATORY **Louisville, Kentucky** 23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE **John Burns' Sons, Towson, Maryland** 25a. REC'D BY REGISTRAR **MAY 11 '61** 25b. REGISTRAR'S SIGNATURE **Charles E. Tissue**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5217

5209

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, Res. before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville			
c. LENGTH OF STAY IN life Life							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Samona Rd.				d. STREET ADDRESS Samona Road			
3 NAME OF DECEASED (Type or print) First Middle Last Clinton Edward Eckert				4. DATE OF DEATH Month Day Year 5-19- 19 61			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 6-23-1879	
9 AGE (In years last birthday) 81 yrs		F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meter installer				10b KIND OF BUSINESS OR INDUSTRY Balto Gas&Elect.			
13. FATHER'S NAME Joseph Eckert				14. MOTHER'S MAIDEN NAME Ellen Fowler			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16 SOCIAL SECURITY NO 212-05-5740			
17 INFORMANT Geo. H. Riley				Address Samona Rd Cockeysville, Md.			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Carcinomatosis Contributing cause (b) Carcinoma of Stomach Cause (c) lying cause last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: INTERVAL BETWEEN ONSET AND DEATH							
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month Day Year Hour a. m. p. m. 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1927 York Rd, Timonium, Md.	
21 I certify that (I) (this hospital) attended the deceased from Feb 8th 1960 to 5/19/ 1961 that () () last saw the deceased alive on 5/17/ 1961 and that death occurred at 4 AM from the causes and on the date stated above.							
22a SIGNATURE M. X. Quinn				22b ADDRESS 1927 York Rd, Timonium, Md.			
22c PHYSICIAN'S NAME (Type) M. KEVIN QUINN				22d ADDRESS 1927 York Rd, Timonium, Md.			
23a BURIAL, CREMATION, REMOVAL, (Specify) Burial				23b DATE THEREOF 5-22-61		23c NAME OF CEMETERY OR CREMATORY Jessop Meth.	
23d LOCATION (City, town, or county) Sparks Maryland				23e REGISTRAR'S SIGNATURE DATE MAY 23 1961			
24 FUNERAL DIRECTOR'S SIGNATURE Irooks Funeral Service Towson 4, Maryland							

(M)

(I)

U



TO HEALTH OFFICIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

05210

1. PLACE OF DEATH

a. COUNTY

Balto.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Catonsville

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

329 Glenmore Ave

3. NAME OF DECEASED

(Type or print)

Ferdinand

5. SEX

M.

W.

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

Dec. 18, 1883

4. DATE OF DEATH

May 2, 1961

9. AGE (In years, months, days, hours, minutes)

77 yrs

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Druggist, Windsor Park, Md.

10b. KIND OF BUSINESS OR INDUSTRY

Pharm.

11. PLACE OF BIRTH

Poland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Egert

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO. (If informant, Add ss)

313-10-0001- Mrs. Clarence F. Fawcett

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

527.1

Pneumonitis, bilateral

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

Bronchiectasis, bilateral

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (b) (c)

Emphysema, pulmonary, bilateral

INTERVAL BETWEEN ONSET AND DEATH

2 days

unknown

unknown

MEDICAL CERTIFICATION

20. AM I CERTAIN THAT I (THE PHYSICIAN) ATTENDED THE DECEASED FROM OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY

Hour a.m. p.m.

Month Day, Year

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Home

21. I certify that I (the physician) attended the deceased from Aug. 1951 to May 2, 1961, that (1) (yes) I saw the deceased alive on May 2, 1961, and that death occurred at 10A, from the causes and on the date stated above

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

Leo J. Gaver, M.D.

22b. ADDRESS

1 Hallow Hill Ave., Baltimore 29 Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

5/5/61

23c. NAME OF CEMETERY OR CREMATORY

St. Paul

23d. LOCATION (City, town or village)

Baltimore

24. FUNERAL DIRECTOR'S SIGNATURE

W. J. H. 401 Edmondson Ave

ADDRESS

25a. REC'D BY REGISTRAR

DATE MAY 5 '61

25b. REGISTRAR SIGNATURE

W. J. H.

25c. REGISTRAR SIGNATURE

W. J. H.



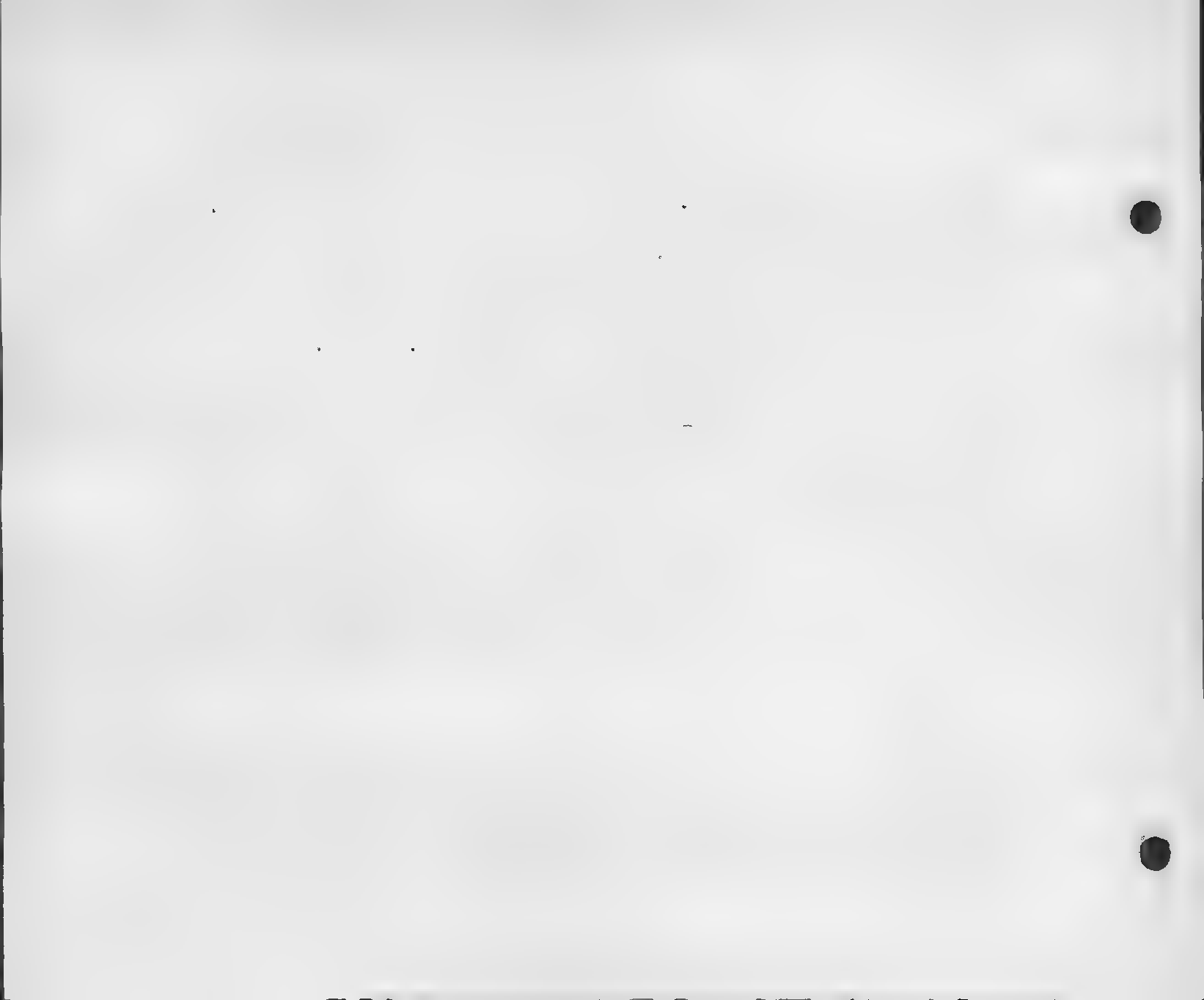
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

5219
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05211

1 PLACE OF DEATH a COUNTY MARYLAND				2 USUAL RESIDENCE (Where deceased lived) a STATE Md b COUNTY Pr			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baynesville				c LENGTH OF STAY IN 1b Life			
d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION St. Luke's				e STREET ADDRESS 12100 York Rd			
3 NAME OF DECEASED (Type or print) First Middle Last Frank J. Rogers				4 DATE OF DEATH Month 5 Day 9 Year 1961			
5 SEX M	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 20, 1931		9 AGE (In years last birthday) 29 yrs		10 IF UNDER YEAR IF UNDER 24 HRS Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) retired				10b KIND OF BUSINESS OR INDUSTRY retl		11 BIRTHPLACE (State or foreign country) Md	
12 CITIZEN OF WHAT COUNTRY? US				13 FATHER'S NAME John Rogers			
14 MOTHER'S MAIDEN NAME Alma Rogers				15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No			
16 SOCIAL SECURITY NO None				17 INFORMANT Dr. Rogers Address 12100 York Rd			
18 CAUSE OF DEATH [Enter any one cause prevailing for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) hypertensive C.V. disease Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last (c) generalized arteriosclerosis PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
INTERVAL BETWEEN ONSET AND DEATH							
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 5/9/61 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Home	
20f (City or town) Pr (County) Pr (State) Md				21 I certify that (I) (this hospital) attended the deceased from 5/5/61 to 5/9/61 19 61 that (I) (we) last saw the deceased alive on 5/5/61 19 61 and that death occurred at 5/9/61 M. from the causes and on the date stated above			
22a SIGNATURE [Signature]				22b DATE SIGNED 5/9/61			
22 PHYSICIAN'S NAME (Type) John Rogers				22d ADDRESS 12100 York Rd			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial				23b DATE THEREOF 5-12-61		23c NAME OF CEMETERY OR CREMATORY St. Luke's	
23d LOCATION (City, town, or county) Pr State Md				24 FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS 1401 Belair Rd			
25a REC'D BY REG. STRAR [Signature]				25b REGISTRAR'S SIGNATURE [Signature]			
DATE MAY 9 1961							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

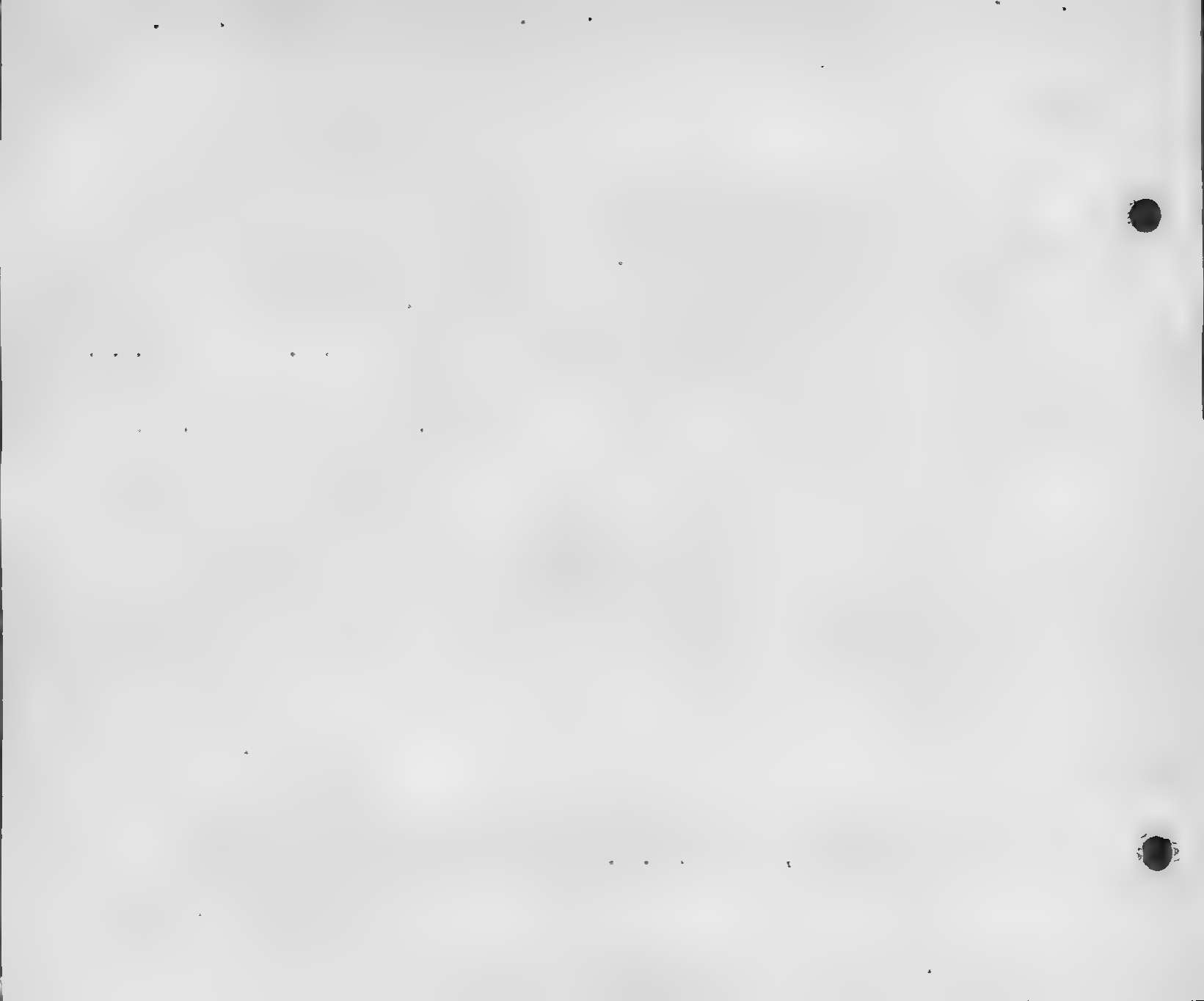
5220

05212

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN b. 101 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived if institution. Reside in b. mission) a. STATE MARYLAND b. COUNTY HANOVER c. CITY OR TOWN (if outside corporate limits, write RURAL) ROUTE 1 d. STREET ADDRESS ROUTE 1 e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRY A. ERICH		4. DATE OF DEATH Month May Day 26 Year 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH February 18, 1880		9. AGE (In years last birthday) 81 yrs. F UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 8 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationery Engineer		10b. KIND OF BUSINESS OR INDUSTRY Government (City)	
11. FATHER'S NAME CHARLES ERICH		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES ERICH		14. MOTHER'S MAIDEN NAME ROSE A BROWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES SPANISH AMERICAN		16. SOCIAL SECURITY NO. FT HOWARD DIVISION	
17. INFORMANT CLIN. RECORDS, VAH, BALTO. MD.		18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COR PULMONALE DUE TO OBSTRUCTIVE EMPHYSEMA DUE TO CHRONIC BRONCHITIS		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION (Enter in Part I or Part II) ARTERIOSCLEROSIS, GENERALIZED		WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. CITY OR TOWN	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 14, 1961 to May 26, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 26, 1961 , and that death occurred 5:50PM from the causes and on the date stated above.			
22a. SIGNATURE Donald W. Stewart M.D.		22b. ADDRESS VAH, BALTIMORE, MARYLAND, FT HOWARD DIV	
22c. PHYSICIAN'S NAME (Type) DONALD W. STEWART, M. D.		22d. LOCATION (City, town, or county) 5608 Dogwood Rd. Woodlawn, Md.	
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/29/61	
23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK		23d. LOCATION (City, town, or county) 5608 Dogwood Rd. Woodlawn, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Austin E. Donovan		25. REC'D BY REGISTRAR Arthur S. Thomas	

Austin E. Donovan Funeral Home, 3818 Roland Ave.
Baltimore, Maryland

DATE JUN 1 '61



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

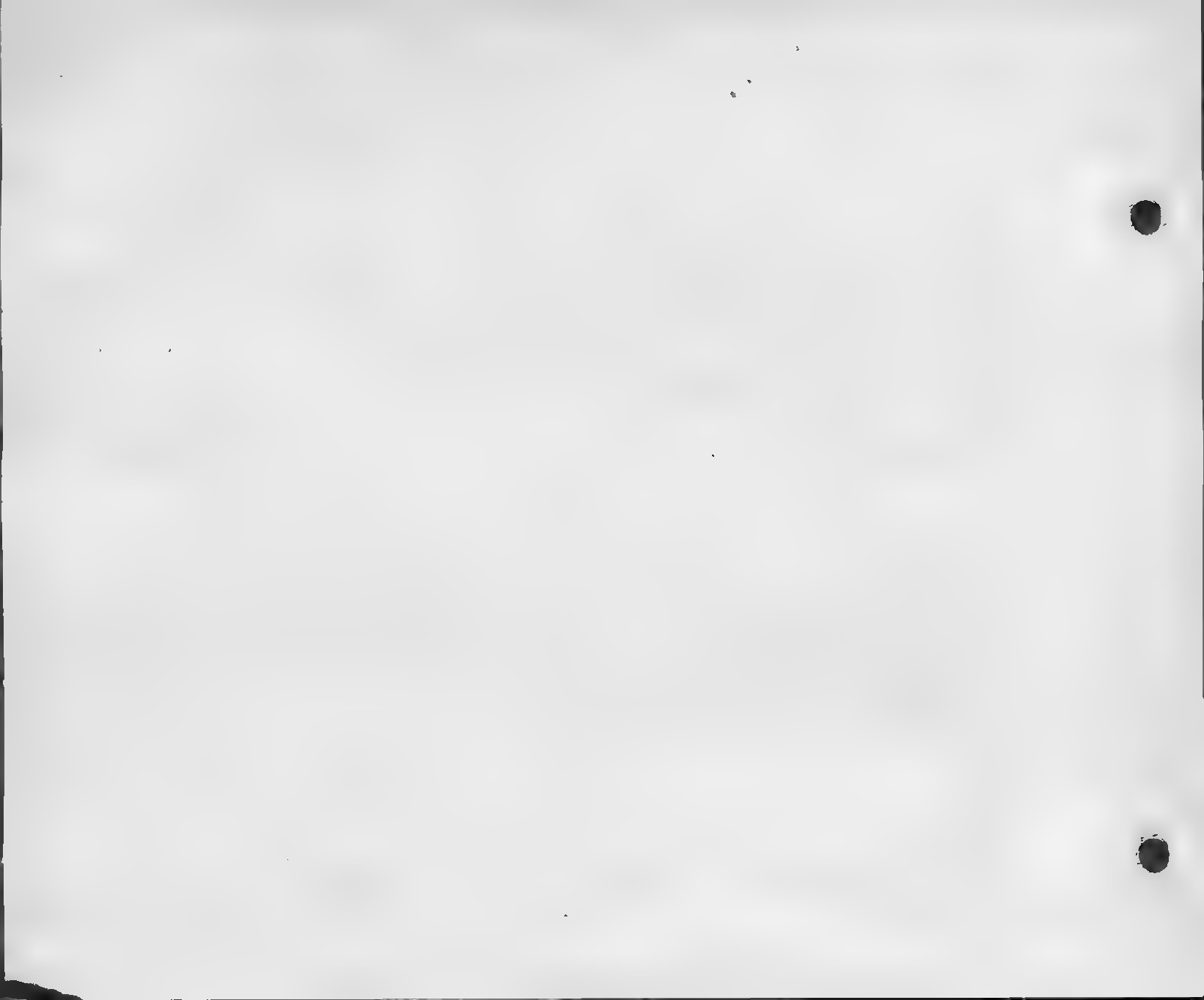
CERTIFICATE OF DEATH

Reg. Dist. No.

05213

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived) If institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c LENGTH OF STAY IN TB <u>17 days</u>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e STREET ADDRESS <u>607 Academy Road</u>	
3 NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Mesterle</u> Last <u>Mesterle</u>		4 DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>19 61</u>	
5 SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct. 19, 1881</u>
9 AGE (In years last birthday) <u>79</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13 FATHER'S NAME <u>Philip E. Kelly</u>		14 MOTHER'S MAIDEN NAME <u>Margaret Torpy</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16 SOCIAL SECURITY NO <u>unknown</u>	
17 INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I attended the deceased from <u>April 28, 19 61</u> to <u>May 14, 19 61</u> , that I last saw the deceased alive on <u>May 14, 19 61</u> , and that death occurred at <u>11:00</u> P. M., from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D.		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>5-15-61</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		<u>Catonsville 28, Md.</u>	
22a BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>		22b. DATE THEREOF <u>5/17/1961</u>	
22c NAME OF CEMETERY OR CREMATORY <u>Burial in St. Mary's Cem.</u>		22d LOCATION (City town or county) (State) <u>LaFayette, Indiana</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Charles Joseph H. H. H.</u>		24a REC'D BY REGISTRAR <u>DATE</u>	
ADDRESS <u>Catonsville Md.</u>		24b REGISTRAR'S SIGNATURE <u>DATE</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5222.

15214

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Towson

c. LENGTH OF STAY (In days)

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Towson

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Green Pasture Drive

d. STREET ADDRESS

Green Pasture Drive

• IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

Ellen

Eyre

4. DATE OF DEATH

Month

Day

Year

May 1, 1961

19

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

8. DATE OF BIRTH

March 1, 1877

9. AGE (In years last birthday)

84 yrs

IF UNDER 1 YEAR

IF UNDER 24 HRS

Months Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (Country and State)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Isaac Sims

14. MOTHER'S MAIDEN NAME

Mary France

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

None

None

17. INFORMANT

Family Records

Address

18. CAUSE OF DEATH (Enter only one cause, unless a, b, and c)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE

DUE TO

gave rise to immediate cause (e), stating the underlying cause last

DUE TO

*Myocardial Infarction
Chronic Hemorrhagic Infarction
A.S.C.V.D.*

INTERVAL BETWEEN ONSET AND DEATH

10+ yrs

10+ yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month Day Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from *10/12, 1960 to 3/1, 1961*, that (I) (we) last saw the deceased alive on *5/1, 1961*, and that death occurred at *12:30 PM*, from the causes and on the date stated above

22a. SIGNATURE

MD

ATTENDING PHYS

MD

DIRECTOR

STAFF PHYS

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

May 4, 1961

23c. NAME OF CEMETERY OR CREMATORY

Providence Cemetery

23d. LOCATION (City, town or county)

Providence, Balto. Co., Md.

24. FUNERAL DIRECTOR'S SIGNATURE

John Burns' Sons, Towson, Maryland

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

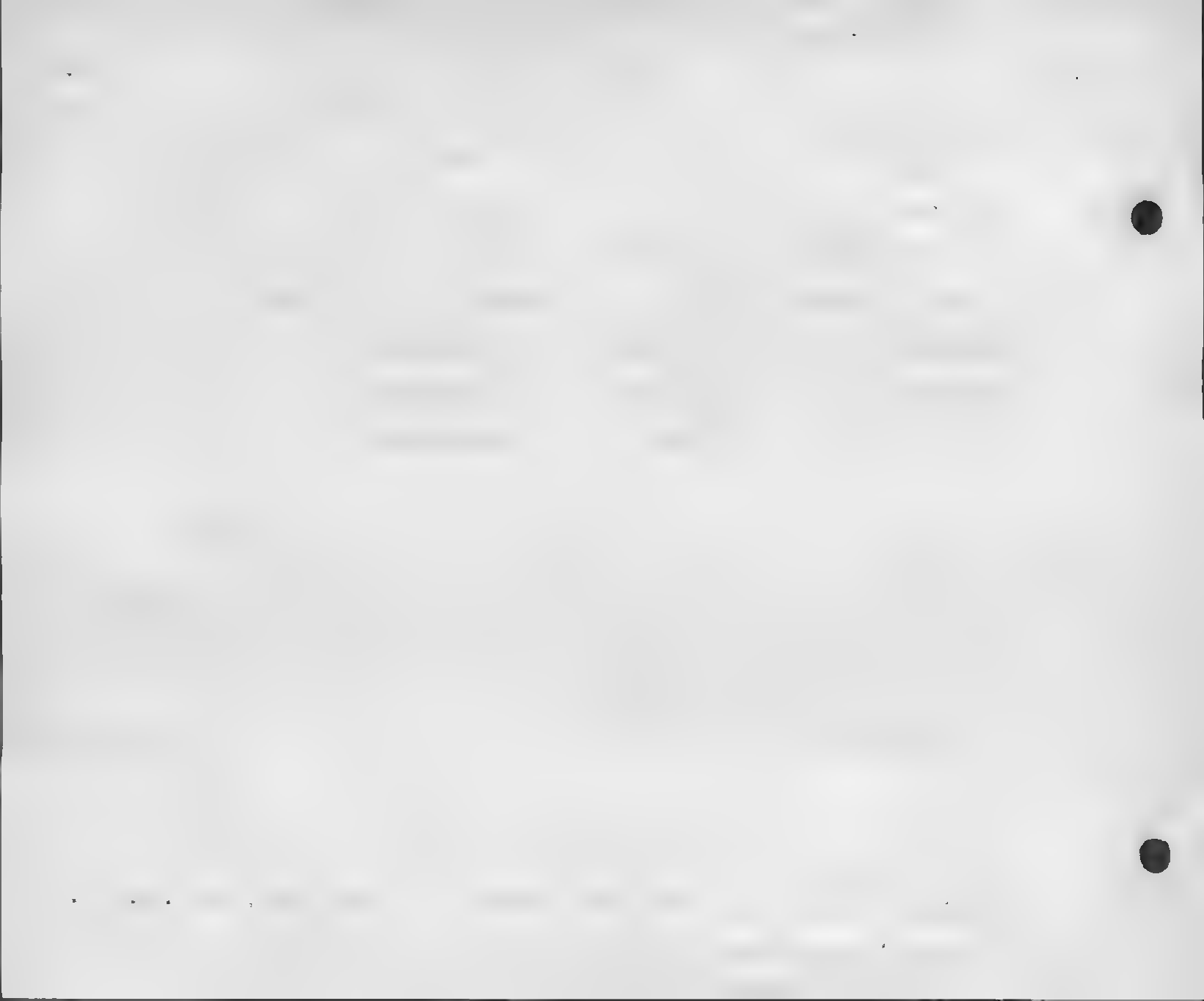
DATE

MAY 8 '61

Arthur S. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15215

1. PLACE OF DEATH
a. CITY OR TOWN Baltimore MARYLAND
b. CITY OR TOWN (outside corporate limits, with RURAL and give nearest town) Baltimore
c. LENGTH OF STAY in b. 14y
d. NAME OF HOSPITAL OR INSTITUTION if not in hospital give street address 1822 Devon
2. USUAL RESIDENCE (where deceased lived. If institution, give name)
a. STATE Md b. COUNTY Balto
c. CITY OR TOWN (outside corporate limits, with RURAL and give nearest town) Balto
d. STREET ADDRESS 1822 Devon
3. NAME OF DECEASED
First Middle Last Gilbert Oscar Faber
4. DATE OF DEATH
Month Day Year May 22 1961
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH
Month Day Year July 7 1907 53 yrs
9. AGE (in years last birthday) UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10. OCCUPATION (Give kind of work) 11. KIND OF BUSINESS OR INDUSTRY (If in business, give name and address) 12. CITIZEN OF WHAT COUNTRY?
mgr. shoe factory shoe factory Maryland of USA
13. FATHER'S NAME Albert Faber 14. MOTHER'S MAIDEN NAME Augusta J. Faber
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No 16. SOCIAL SECURITY NO. 1-22-777 17. INFORMANT
Name Address Julia Faber 1822 Devon
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)
1-0-1 DUE TO Acute Coronary Thrombosis Sudden
Conditions, if any, which gave rise to immediate cause (b) Unk.
(e), stating the underlying cause last. DUE TO Unk.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.
19. Was AUTO SYPH PERFORMED? ☒ NO ☐ YES
20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19 53 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐
death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
ACTUAL SIGNATURE Frank T. Kasik, Jr. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) FRANK T. KASIK, JR. ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county, State) 5/22/61
22a. DATE OF CREMATION 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county, State)
23. FUNERAL DIRECTOR James J. Schaefer, Son, North & Sons, Baltimore, Md. ADDRESS Baltimore, Md.
24a. REC'D BY REGISTRAR MAY 24 '61 24b. REGISTRAR'S SIGNATURE Clara P. Harris



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. Page 4

VR A15 (4)
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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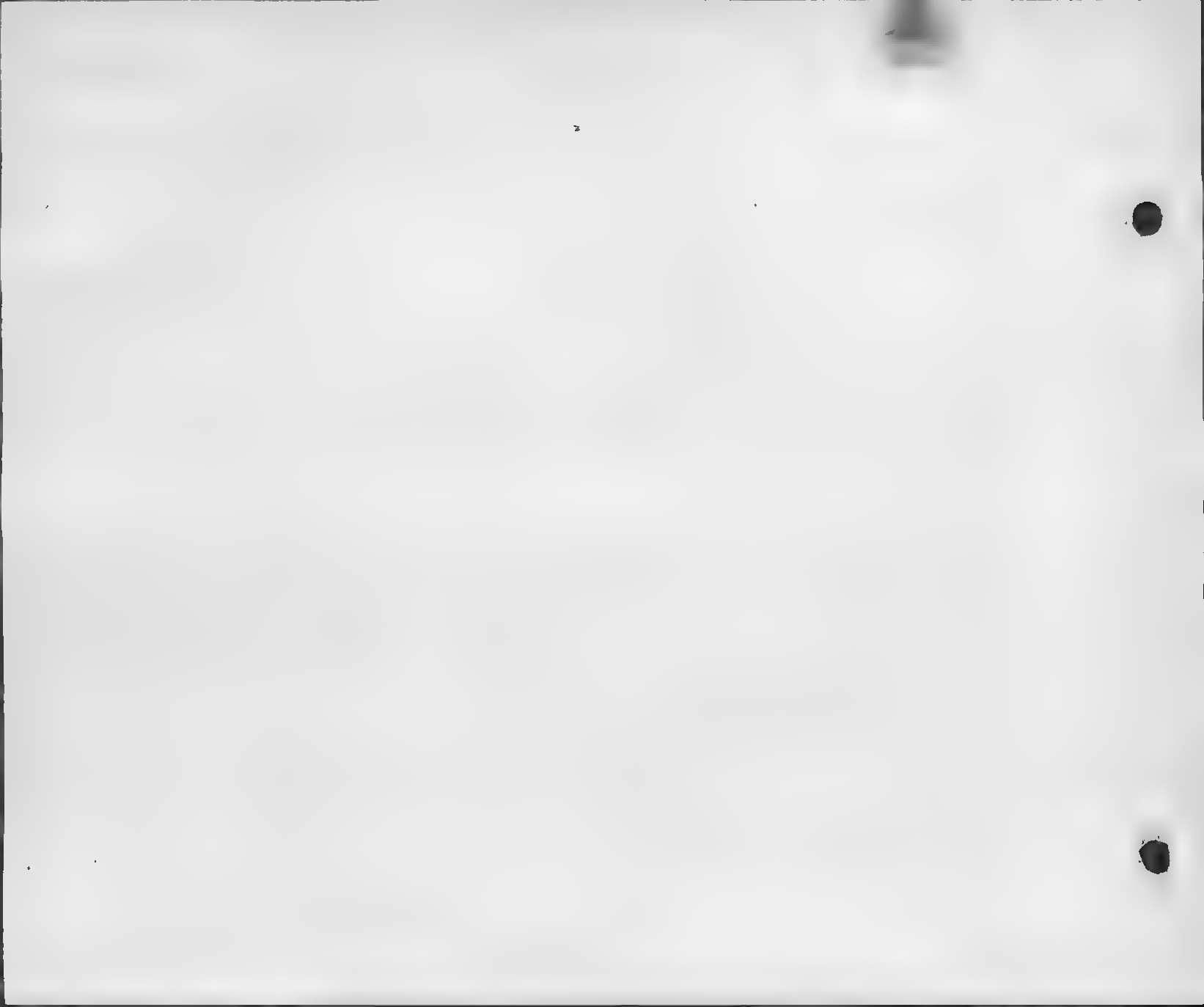
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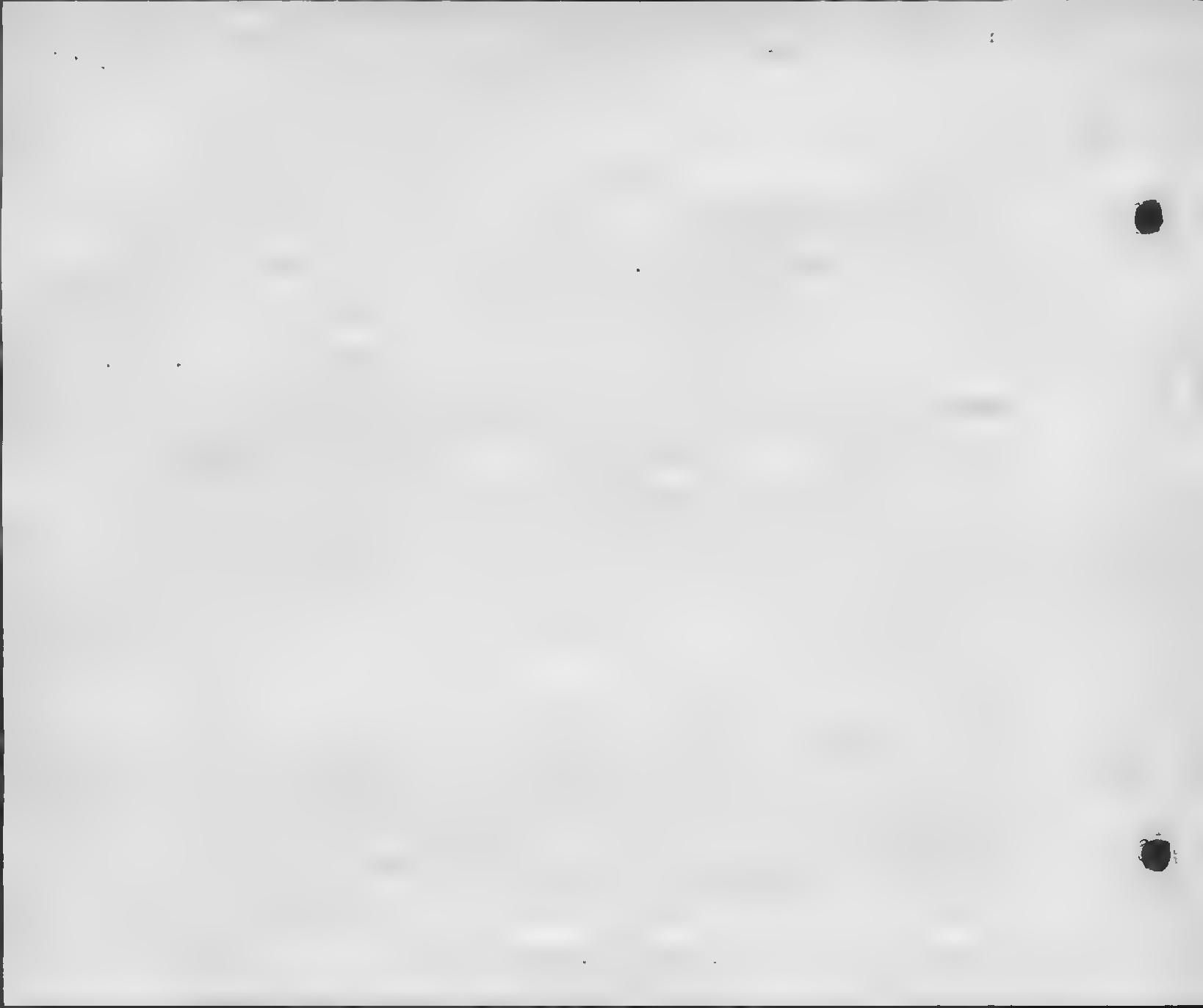
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5216

1 PLACE OF DEATH a. COUNTY MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) BALTIMORE 2	
d. NAME OF HOSPITAL (If not in hospital give street address OR INSTITUTION) 1200 VALLEY STREET		e. STREET ADDRESS 1200 VALLEY STREET	
3 NAME OF DECEASED (Type or print) THOMAS JOSEPH FARRILL		4. DATE OF DEATH Month 5 - Day 14 - Year 1941	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-16-85
9 AGE (In years last birthday) 56		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months 2 Days 24 Hours 1 M n	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) CLERK		10b KIND OF BUSINESS OR INDUSTRY CLERICAL	
11 BIRTHPLACE (State or foreign country) NEW YORK		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME PETER FARRELL		14 MOTHER'S M A DEN NAME BRIDGET MALARY	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16 SOCIAL SECURITY NO 213-28-8533	
17 INFORMANT (If yes, give name and address) JOSEPH FARRELL		18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I INTERVAL BETWEEN ONSET AND DEATH 2 YEARS	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) _____ County _____ (State) _____	
21 I certify that (I) (this hospital) attended the deceased from 5-2-1941 to 5-24-1941 that (I) (we) lost saw the deceased alive on 5-22-1941 and that death occurred at 7:15 A.M. from the causes and on the date stated above			
22a SIGNATURE Philip Herwig Sons		22b DATE SIGNED 5-24-41	
22c PHYSICIAN'S NAME (Type) Philip Herwig Sons		22d ADDRESS 1200 VALLEY STREET	
23a BIRTH REMOVAL Removal May 26/41		23b DATE THEREOF May 26/41	
23c NAME OF CEMETERY OR CREMATORY Cathedral Cem. Baltimore		23d LOCATION (City, town, or county) _____	
24 FUNERAL DIRECTOR'S SIGNATURE Philip Herwig Sons		25a REC'D BY REGISTRAR 2624	
25b REGISTRAR'S SIGNATURE Orleans St		25c DATE 5-24-41	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05218

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) b. STATE <u>Ind.</u> c. COUNTY <u>Dea. Co. Ind.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burr 7</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town, #11) <u>N. S. Pacific Health Hosp. #11</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Robb Nursing Home</u>		d. STREET ADDRESS (If other than of residence, give address) <u>WYMAN PARK DRIVE</u>	
3. NAME OF DECEASED (Type or print) <u>Charles D. Fishburn</u>		4. DATE OF DEATH <u>May 19 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13, 1878</u>
9. AGE (In years past birthday) <u>82</u> yrs		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>the farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Houston D. Fishburn</u>		14. MOTHER'S MAIDEN NAME <u>Laura</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>C</u>	
17. INFORMANT <u>Mrs. Stella E. Fishburn, nursing home</u>		Address <u>Robb Nursing Home</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intersected roads, grazed</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. [City or town] _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>4-27</u> , 19 <u>61</u> , to <u>May 19</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>5-8</u> , 19 <u>61</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Charles H. Williams</u> M.D. <u>1632 Pennsylvania Ave.</u>		ADDRESS (Street, city or town, state) _____ DATE SIGNED _____	
PHYSICIAN'S NAME (Type) <u>Charles H. Williams</u>		<u>Pikeville, Ind.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAY 10, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BURR OAK</u>	22d. LOCATION (City, town, or county) (State) <u>KANSAS</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul E. Hennrich</u> ADDRESS <u>3617 Chestnut Ave</u>		24a. REC'D BY REGISTRAR <u>MT</u> DATE _____	24b. REGISTRAR'S SIGNATURE _____

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be filed with the hospital or attending physician. TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

15210

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shadyside, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS none	
3 NAME OF DECEASED (Type or print) First Middle Last Jane Elizabeth Forker		4 DATE OF DEATH Month Day Year May 31 1961	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 15, 1882
9 AGE (In years last birthday) 79		FUND 1 YEAR IF UNDER 24 HRS Months Days Hours M'n	
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Washington, D. C.		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME George Jarreant		14 MOTHER'S MAIDEN NAME Annie Strattan	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16 SOCIAL SECURITY NO. unknown	
17 INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerosis, generalized, severe. DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from May 15, 1961, to May 31, 1961, that I last saw the deceased alive on May 31, 1961, and that death occurred at 1:45 P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE Stella Wachslor		DATE SIGNED MAY 31 1961	
PHYSICIAN'S NAME (Type) Stella Wachslor M.D.		Catonsville 23, Maryland	
22a BURIAL, REMOVAL, OR CREMATION (Specify) Burial		22b DATE THEREOF 6-3-61	
22c NAME OF CEMETERY OR CREMATORY Glenwood		22d LOCATION (City, town, or county) (State) Washington D.C.	
23 FUNERAL DIRECTOR'S SIGNATURE J. L. L...		ADDRESS DATE	
24a REC'D BY REGISTRAR DATE		24b REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5228

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05220

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 9mth28days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown, Maryland		d. STREET ADDRESS Box 270 Liberty Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Fortin Last Fortin		4. DATE OF DEATH Month May Day 12 Year 19 61	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 November 1874
9. AGE (In years last birthday) 86 yrs		10. FLUNDER 1 YEAR Months 8 Days 12 Hours 19 Min 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown Simon Engle		14. MOTHER'S MAIDEN NAME unknown Mary Graybill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Arteriosclerotic cardiovascular disease Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 11, 1960 to May 12, 1961 , that I last saw the deceased alive on May 12, 1961 , and that death occurred at 11:20 p.m. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 5-12-61			
ACTUAL SIGNATURE Stella Wachslar M.D.		PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/18/61	
22c. NAME OF CEMETERY OR CREMATORY Bainbridge Cemetery, Lanc. Co., Pa.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE James G. Smith		24a. REC'D BY REGISTRAR DATE MAY 17 '61	
24b. REGISTRAR'S SIGNATURE Wm. L. Kram			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5228

CERTIFICATE OF DEATH

05221

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived) If institutional Residence before admission a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessups, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>JOHN G. BRADY STATE HOSPITAL</u>		d. STREET ADDRESS <u>20 Mat evideo Court</u>	
3 NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>D.</u> Last <u>Frage</u>		4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1961</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8 DATE OF BIRTH <u>Feb. 22, 1871</u>	9 AGE in years last birthday <u>90</u> yrs IF UNDER 1 MONTHS Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>watchman</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Germany</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13 FATHER'S NAME <u>un. own</u>		14 MOTHER'S MAIDEN NAME <u>un. own</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>unknown</u>	
17 INFORMANT <u>Records ; SPRING GROVE STATED HOME</u>		Address	
18 CAUSE OF DEATH [Enter on only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio sclerotic cardiovascular disease</u> DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour o m p m	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>May 22</u> 19 <u>61</u> , to <u>May 24</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>May 24</u> 19 <u>61</u> and that death occurred at <u>12:20</u> P. M. from the causes and on the date stated above			
22a SIGNATURE <u>Stella Wachslar</u>		22b ADDRESS <u>SPRING GROVE STATE HOME, Catonville 24, Maryland</u>	
22c PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		22d ADDRESS <u>SPRING GROVE STATE HOME, Catonville 24, Maryland</u>	
23a BURIAL OR CREMATION <input type="checkbox"/> REMOVAL <input type="checkbox"/> (Specify)		23b DATE THEREOF <u>May 27/61</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		23d LOCATION (City, town, or county) <u>15th Avenue, Baltimore</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>James J. Tait</u>		25 REGISTRAR'S SIGNATURE <u>James J. Tait</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

5230

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05222

1 PLACE OF DEATH a. COUNTY BALTO b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2107 ROCKWELL AVE.		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence 1 in 1b) a. STATE MD. b. COUNTY BALTO. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE d. STREET ADDRESS 2107 ROCKWELL AVE.	
3. NAME OF DECEASED (Type or print) VIRGINIA FIRANZONI		4. DATE OF DEATH Last First Middle MAY 12 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH MARCH 19, 1882	9. AGE (In years) IF UNDER 1 YEAR Months Days Hours Min 79 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (Country & State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH FREGUSI		14. MOTHER'S M.A.DEN NAME JULIA CATIZZI	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 12-01-100000-0000	
17. INFORMANT Shirley Balzano - 2107 Rockwell Ave		Address	
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation. 4-1-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c)		INTERVIEW BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. City or town: (Country) (State)	
21 I certify that (I) (this hospital) attended the deceased from May 10, 1956 to 5/12/61 , 19 61 , that (I) (we) last saw the deceased alive on 5/4/61 , 19 61 , and that death occurred at 9:45 a.m. from the causes and on the date stated above			
22a. SIGNATURE John R. Davis, M.D.		22b. DATE SIGNED May 15, 1961	
22c. PHYSICIAN'S NAME (Type) John R. Davis, M.D.		22d. ADDRESS 401-2 Med. Arts Bldg., Balto. 1, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 15-16-61		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Catholic Cem		23d. LOCATION (City, town or county) (State) Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John R. Davis, M.D.		25a. REC'D BY REGISTRAR MAY 18 '61	
ADDRESS Catonville, Md.		25b. REGISTRAR'S SIGNATURE Arthur R. Davis	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7231

05223

1. PLACE OF DEATH

a. COUNTY

M

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Catonville

c. LENGTH OF STAY IN 1b

3 weeks

d. NAME OF HOSPITAL OR INSTITUTION, if not in hospital give street address

House in the Pines

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before death)

a. STATE

b. COUNTY

Ind

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore

d. STREET ADDRESS

424 N. Pulaski St.

e. RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

Edward W. Frederick Jr.

4. DATE OF DEATH

Month Day Year
5 24 1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

☐ NEVER MARRIED ☒ MARRIED

8. DATE OF BIRTH

12/10/1879

9. AGE (In years last birthday)

81 yrs

10. UNDER 1 YEAR IF UNDER 21 HRS

Months Days Hours Min.

10a. USUAL OCCUPATION, if no kind of work done during most of working life, even if retired

Car Builder

10b. KIND OF BUSINESS OR INDUSTRY

B+O. R. R.

11. PLACE OF BIRTH

Germany

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give word or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT

Mr. Edward W. Frederick Jr. Wilhelm

18. CAUSE OF DEATH (Enter only one cause pertaining to a, b, and c)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

420.1 DUE TO
Conditions of any, which gave rise to immediate cause (a), stating the underlying cause last.

*Coronary Occlusion
ARTERIAL SCLEROSIS*

INTERVAL BETWEEN ONSET AND DEATH

Immediate

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.

20d. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from *October 1960* to *MAY 24 1961*, that (I) (we) last saw the deceased alive on *MAY 24 1961*, and that death occurred at *3 PM*, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME Type

HERBERT W. LAPP

M.D.

ATTENDING PHYS.

22d. ADDRESS

22e. ADDRESS

STAFF PHYS.

22f. ADDRESS

22g. ADDRESS

22h. ADDRESS

22i. ADDRESS

22j. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

5/27/61

23c. NAME OF CEMETERY OR CREMATORY

New Cathedral Cem.

23d. LOCATION (City, town or county)

4300 Old Frederick Rd.

24. FUNERAL DIRECTOR'S SIGNATURE

John J. Cowan

ADDRESS

90 Hollins St.

25a. REC'D BY REGISTRAR

MAY 29 '61

25b. REGISTRAR'S SIGNATURE

Anthony S. Hines

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER DEATH. THE ATTENDING PHYSICIAN AND COMPLETED BY THE FUNERAL DIRECTOR. AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETED BY THE FUNERAL DIRECTOR, PAGE 3 SHOULD BE DETACHED FOR USE AS THE BURIAL TRANSIT PERMIT. THEN PLEASE REMOVE CARBON PAGES 1 AND 2 AND RETURN TO THE STATE DEPT. OF HEALTH PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT, WITHIN 24 HOURS AFTER DEATH.



FOR STATE
HEALTH DEPT.

TO DEPARTMENTAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

232 15224

1. PLACE OF DEATH
a. COUNTY Balti. MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Reisterstown
c. LENGTH OF STAY in 1b 8 y 2 m
d. NAME OF HOME OR INSTITUTION (if not in hospital, give street and no.) 1105 5th St. N. Reisterstown, Md.
e. STREET ADDRESS
f. ON A FARM? ☒ NO ☐ YES

2. USUAL RESIDENCE (Where deceased lived, if instituted in Person)
a. STATE Md. b. COUNTY Balti.
c. CITY OR TOWN (if outside corporate limits, write RURAL) Reisterstown, Md.
d. STREET ADDRESS
e. ON A FARM? ☒ NO ☐ YES

3. NAME OF DECEASED (Type or print) ESTHER NAITS GAVITT
4. SEX F 5. COLOR OR RACE W 6. MARRIED ☐ NEVER MARRIED ☐ 7. DATE OF BIRTH 11-22-1882 8. AGE (in yrs. mo. da.) 76 y 10 m 14 d
9. ALICE (in yrs. mo. da.) 76 y 10 m 14 d 10. BIRTHDAY 11-22-1882 11. BIRTHPLACE (State or foreign country) Belgium 12. PLACE OF BIRTH Belgium
13. FATHER'S NAME John Smith 14. MOTHER'S MAIDEN NAME Mary Ann Gantt
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch of service) No 16. SOCIAL SECURITY NO. 3-22-24 17. INFORMANT John Gantt - Same
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure
DUE TO Coronary artery disease
Conditions, if any, which gave rise to immediate cause (b) None
DUE TO None
(c) None
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (COND. IN GIVEN N.P.A.) None
19. V. PERFORMED? YES ☐ NO ☐
20a. EXTERNAL CAUSE OF DEATH None 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None
20c. TIME OF INJURY Month 11 Year 19 20d. INJURY OCCURRED None 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None
20f. (City or town) None
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER [Signature]
M.D. ASSISTANT MEDICAL EXAMINER ☐ DATE SIGNED 11-21-61
DEPUTY MEDICAL EXAMINER ☒
Address Street, city, town or county 1105 5th St. N. Reisterstown, Md.
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 11-21-61 22c. NAME OF CEMETERY OR CREMATORY North Penna. Ave. Bk. 17, 12th 22d. LOCATION (City, town, or county) Baltimore, Md.
23. FUNERAL DIRECTOR John G. Lohman 24a. REC'D BY REGISTRAR [Signature] 24b. REGISTRAR'S SIGNATURE [Signature]
DATE NOV 31 '61

M

I





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05226

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN, if outside corporate limits, write RURAL and give nearest town) Fort Howard
c. LENGTH OF STAY IN b 244 Days
d. NAME OF HOSPITAL OR INSTITUTION, if not in hospital, give street address) Veterans Administration Hospital
e. STREET ADDRESS 414 East 25th Street (10)
f. IS RESIDENCE ON A FARM? YES ☐ NO ☒
2. USUAL RESIDENCE (Where deceased lived, if inst. in residence)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN, if outside corporate limits, write RURAL and give nearest town) Baltimore
3. NAME OF DECEASED
First Middle Last
EDGAR M. GARRETT
4. DATE OF DEATH
Month Day Year
May 13 1961
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH
Month Day Year
December 23, 1890
9. AGE in years (last birthday) 72 yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carman
11. NO. OF BUSINESS OR INDUSTRY Railroad
12. TOWN OF WHAT COUNTRY? Harford County, Maryland
13. FATHER'S NAME Emory W. Garrett
14. MOTHER'S MAIDEN NAME Margaret R. Meredith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes
16. SOCIAL SECURITY NO. WW I 705-10-6451
17. INFORMATION Clinical Records
18. PLACE OF DEATH VAH, Baltimore 10, Maryland, Ft. Howard Division

18. CAUSE OF DEATH (Enter only on cause part line, or a, b, or c.)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA

Condition(s) which gave rise to immediate cause, stating the underlying cause last.

(b) CARCINOMA OF BLADDER, RECURRENT WITH METASTASES TO LUNG, LIVER AND ADRENAL
(c) CHRONIC PYELONEPHRITIS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

Arteriosclerotic Heart Disease - Duration unknown

20a. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OF CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 1961
20d. INJURY OCCURRED
While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)
20g. (State)

21. I certify that (X) (this hospital) attended the deceased from September 16, 1961, to May 10, 1961 that (X) (we) last saw the deceased alive on May 18, 1961, and that death occurred on May 13, 1961, from the causes and on the date stated above.

22a. SIGNATURE THOMAS F. CRAHAN, M.D.
22b. DATE 5/18/61
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS VAH, BALTIMORE 10, MD., FT. HOWARD DIVISION
22e. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22f. ADDRESS

23a. BURIAL CREMATION REMOVAL Burial 23b. DATE THEREOF 5-20-61 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial 23d. LOCATION (City, town or county) Baltimore (State) Maryland

24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons, Inc. ADDRESS North & Penna. Aves. Balto. 25a. REC'D BY REGISTRAR MAY 19 1961 25b. REGISTRAR'S SIGNATURE L. H. HARRIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

MARYLAND STATE DEPARTMENT OF HEALTH

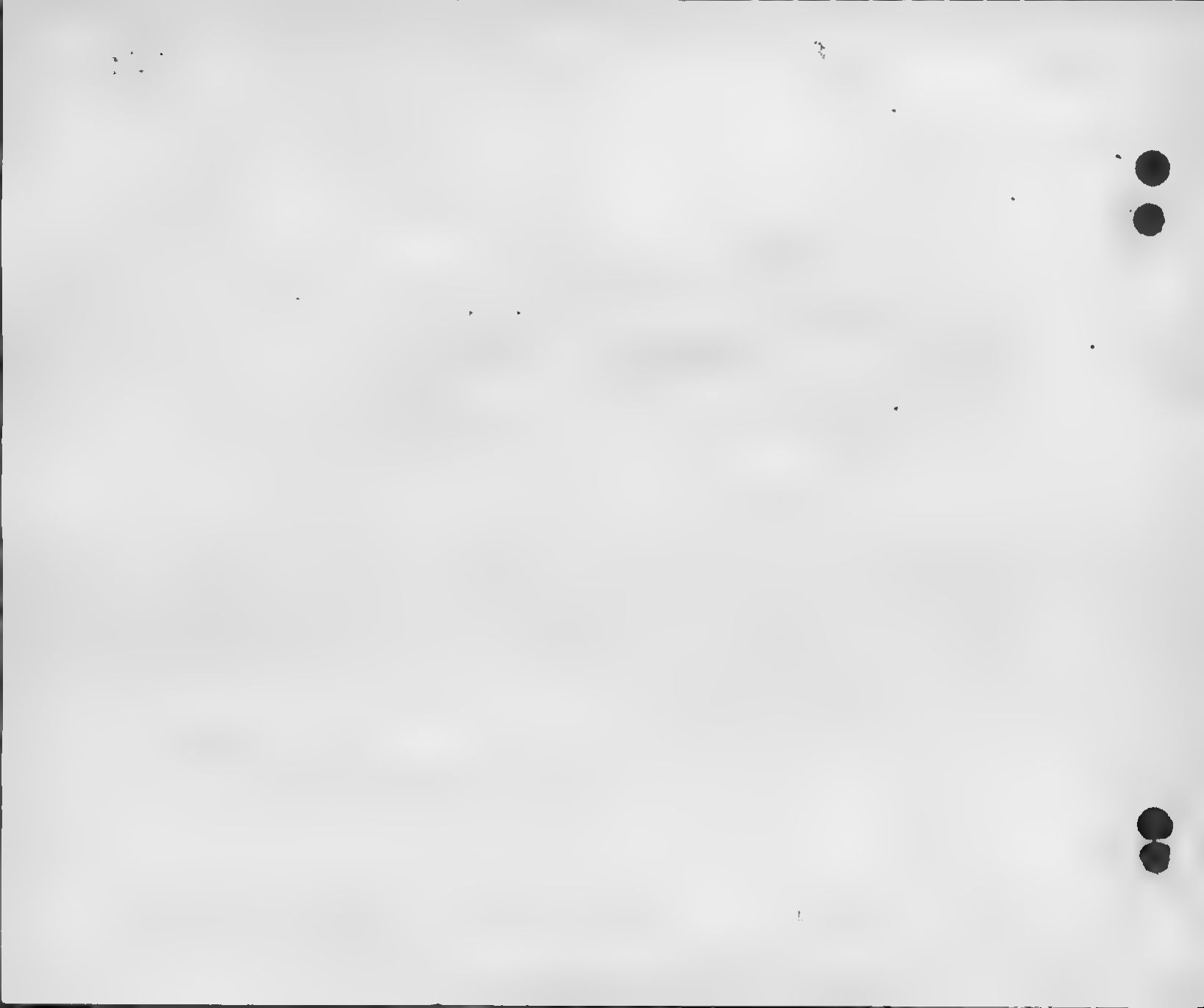
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5235

05227

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) COCKEYSVILLE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) FALLS ROAD		2. USUAL RESIDENCE Where deceased lived. If institution, give name and address a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) COCKEYSVILLE d. STREET ADDRESS FALLS ROAD	
3. NAME OF DECEASED (Type or print) First EDWARD Middle P Last GENT		4. DATE OF DEATH Month MAY Day 2 Year 19 61	
5. SEX MALE 6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH JAN. 18, 1980 9. AGE (in years) 81 yrs. IF UNDER 1 YEAR: Months 1 Days 1 Hours 1 Mins 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER 10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		11. BIRTH PLACE & State (or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ORRICK W. GENT		14. MOTHER'S MAIDEN NAME HANNA COX	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. NONE		17. INFORMANT FAMILY RECORDS Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE DUE TO 4-2-1 Conditions, if any, which gave rise to immediate cause (b) _____ DUE TO (a), stating the underlying cause last (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) 20f. City or town _____ County _____ State _____	
21. I certify that (I) (this hospital) attended the deceased from... MAY 1958 to MAY 1961 , that (I) (we) last saw the deceased alive on... MAY 1961 , and that death occurred on MAY 2, 1961 , from the causes and on the date stated above.			
22a. SIGNATURE William M. Pillsbury		22b. DATE SIGNED 5/5/61	
22c. PHYSICIAN'S NAME (Type) WILLIAM M. PILLSBURY		22d. ADDRESS 200 YACARD TOWN...	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/5/61	
23c. NAME OF CEMETERY OR CREMATORY GRACE METHODIST CEMETERY		23d. LOCATION (City, town or county, State) FALLS ROAD, COCKEYSVILLE	
24. FUNERAL DIRECTOR'S SIGNATURE John L. ...		25a. REC'D BY REGISTRAR MAY 8 '61 25b. REGISTRAR'S SIGNATURE Charles L. ...	



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the attending physician or the funeral director. After the certificate has been signed by the attending physician and completely filed by the funeral director to the FUNERAL DIRECTOR, After the certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

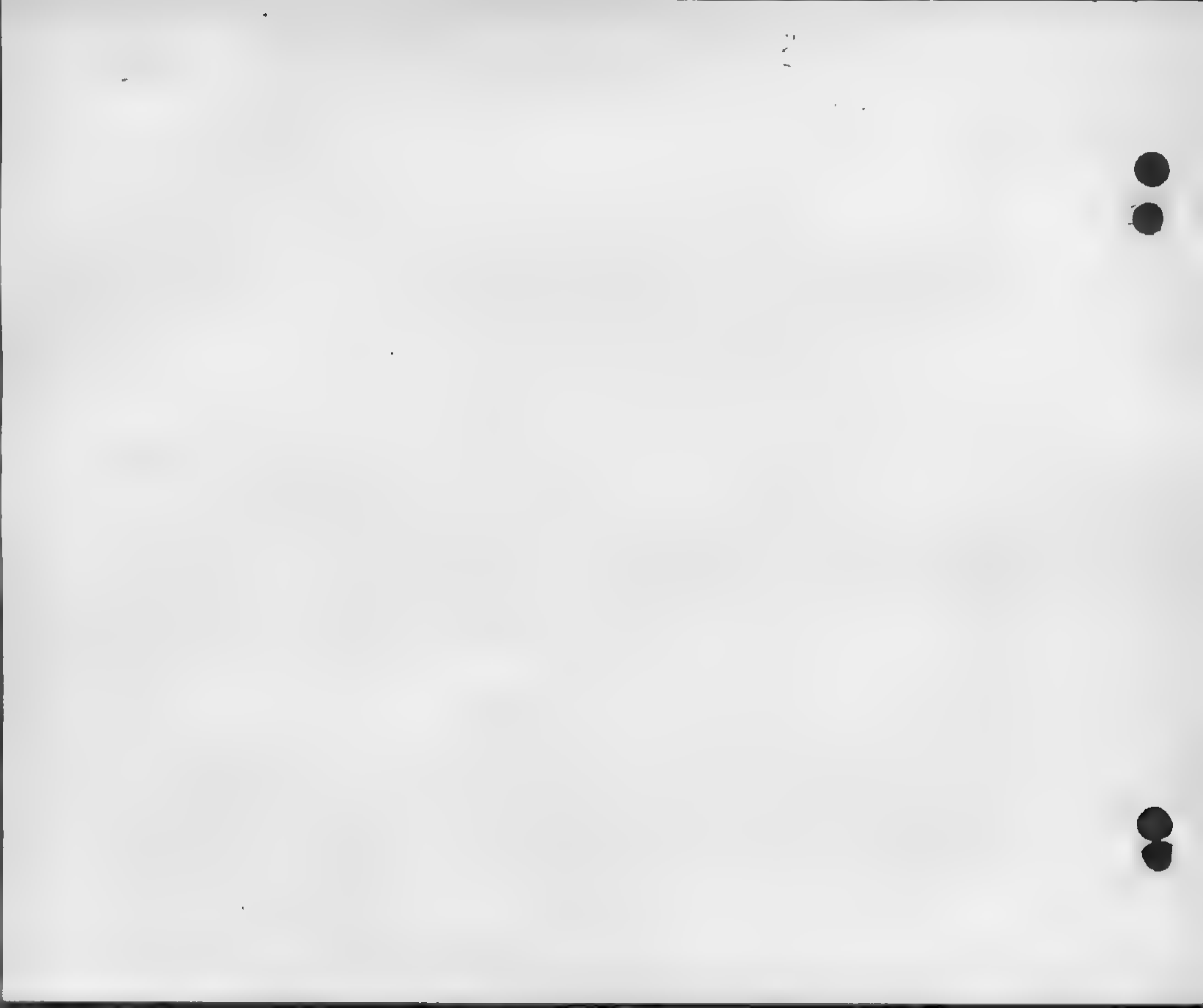
5236
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15228

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>RURAL - WOODMONT</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WOODMONT</u>			
d. NAME OF HOSPITAL (If, not in hospital, give street address) OR INSTITUTION <u>5712 WOODMONT AVE</u>				e. STREET ADDRESS <u>5712 WOODMONT AVE</u>			
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>JOHN</u> Middle <u>JOHN</u> Last <u>JOHN</u>				4. DATE OF DEATH Month <u>5</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NORFOLK VIRGINIA</u>	
9. AGE (In years last birthday) <u>70</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>		IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CARPENTER</u>			
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JOHN WILLESPIE</u>				14. MOTHER'S MAIDEN NAME <u>ALICE GETTY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>1-018-1-111</u>			
17. INFORMANT <u>Belvien Ave</u> address <u>Belvien Ave</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO <u>PROLONGED ILLNESS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>PROLONGED ILLNESS</u> DUE TO <u>PROLONGED ILLNESS</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONTRIBUTING TO DEATH</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m p m 19 <u>5/13/61</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5/13/61</u> to <u>5/15/61</u> , that (I) (we) last saw the deceased alive on <u>5/13/61</u> and that death occurred at <u>8:00 AM</u> from the causes and on the date stated above				22a. SIGNATURE <u>John J. Smith</u>			
22c. PHYSICIAN'S NAME (Type) <u>John J. Smith</u>				22b. DATE <u>5/15/61</u>			
23a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>5/17/61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>				23d. LOCATION City, town, or county State <u>BALTO. MD.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Smith</u> ADDRESS <u>1212 17th St.</u>				25a. REC'D BY REGISTRAR <u>John J. Smith</u> 25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>			

THE LOW requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>Life</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>							
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>A.</u> Last <u>Gleitsman</u>				4. DATE OF DEATH Month <u>5</u> Day <u>24</u> Year <u>1961</u>				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1911</u> 9. AGE (In years at birthday) <u>50</u> 10. IF UNDER 1 YEAR Months <u>15</u> Days <u>15</u> 11. IF UNDER 24 HRS Hours <u>15</u> Min <u>45</u>				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (State or foreign country) <u>Balto. Co.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John H. Koppelman</u> 14. MOTHER'S MAIDEN NAME <u>Annie Weber</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO <u>None</u> 17. INFORMANT <u>Miss Gladys Gleitsman</u> Address <u>7118 Bristol Rd</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>OCCLUSION OF CORONARY ARTERY</u> (b) <u>ARTERIOSCLEROSIS</u> (c) <u>SENILITY</u> PART OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 18 <u>CANCER OF BREAST</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <u>NONE</u> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) 20c. TIME OF INJURY Month, Day, Year <u>May 24 1961</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Home</u> 20f. (City or town) <u>Baltimore</u> (County) <u>Baltimore</u> (State) <u>Md.</u>											
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 15</u> <u>1956</u> to <u>May 24</u> <u>1961</u> , that (II) (we) lost <u>the deceased</u> alive on <u>May 23</u> <u>1961</u> and that death occurred on <u>May 24</u> <u>1961</u> at <u>8:15</u> P.M. from the causes and on the date stated above 22a. SIGNATURE <u>A.S. Chalfant</u> 22b. DATE <u>May 26 1961</u> 22c. PHYSICIAN'S NAME (Type) <u>A.S. CHALFANT</u> 22d. ADDRESS <u>6210 YORK ROAD, BALTIMORE, MD.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>5-27-1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u> 23d. LOCATION (City, town, county, state) <u>Baltimore, Md.</u>											
24. F. FUNERAL DIRECTOR'S SIGNATURE <u>James A. ...</u> ADDRESS <u>...</u> 25a. REC'D BY REGISTRAR <u>MAY 29 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN - The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician and be retained by the hospital or attending physician. TO FUNERAL DIRECTOR - After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05230
CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY **Baltimore**
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) **Fort Howard**
c. LENGTH OF STAY IN IL **3 Days**
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) **Veterans Administration Hospital**

2. USUAL RESIDENCE (Where deceased lived first 60 days of life or longest period of residence)
a. STATE **Maryland**
b. COUNTY **Baltimore**
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) **Baltimore**
d. STREET ADDRESS **1514 Leslie Road**

3. NAME OF DECEASED (Type or print)
Served as PETER PAUL GOLABOSKI SR. (PETER PAUL GOLABOWSKI, SR.)

4. SEX **Male**
5. COLOR OR RACE **White**
6. MARRIED ☒ NEVER MARRIED ☐

7. DATE OF BIRTH **October 12, 1895**
8. DATE OF DEATH **May 28, 1961**

9. AGE in years (If under 1 year, last birthday) **65** yrs
10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Machinist**
b. KIND OF BUSINESS OR INDUSTRY **Sugar Refinery**
c. BIRTHPLACE (Country & State, or foreign country) **Baltimore Maryland**
d. CITIZEN OF WHAT COUNTRY? **U.S.A.**

11. FATHER'S NAME **Joseph Golabowski**
12. MOTHER'S MAIDEN NAME **Agnes Kotyres**

13. WAS DECEASED EVER IN U.S. ARMED FORCES? **Yes**
14. SOCIAL SECURITY NO. **212-09-6360**
15. INFORMANT **CLIN REC VAH BALTIMORE MD- FT HOWARD DIVISION**
Address **1514 Leslie Road**

16. CAUSE OF DEATH (Enter only one cause, perinatal, etc.)
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE **CARDIAC ARRHYTHMIA**
XXXX DUE TO ATRIAL FIBRILLATION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) **DUE TO ARTERIOSCLEROTIC HEART DISEASE**
GENERALIZED ARTERIOSCLEROSIS

17. INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN
1 YEAR
UNKNOWN

18. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO THE TERMINAL DISEASE OR CONDITION, IF ANY
PULMONARY INFARCTION. CHRONIC CONGESTIVE FAILURE

19. a. ACCIDENT WAS UNEXPECTED OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury, place, time, etc.)
20. a. TIME OF INJURY (Month, Day, Year) **May 25, 1961**
b. INJURY CURRENTLY OF INJURY (Home, farm, factory, street, office bldg., etc.) **at work**

21. I certify that (X) (this hospital) attended the deceased from May 25, 1961, to May 28, 1961, that (X) (we) last saw the deceased alive on May 26, 1961, and that death occurred at P.M. from the causes and on the date stated above.

22. SIGNATURE **HOWLAND H. ROBERTSON, JR. M.D.**
23. DATE **5-29-61**

24. a. BURIAL, CREMATION, REMOVAL (Specify) **Burial**
b. DATE THEREOF **6-2-61**
c. NAME OF CEMETERY OR CREMATORY **St Stanislaus Cemetery**
d. LOCATION (City, town or village) **Baltimore Maryland**

25. a. RECD BY REGISTRAR **Charles F. Zeller**
b. REGISTRAR'S SIGNATURE **Charles F. Zeller**
c. ADDRESS **6224 Eastern Ave Baltimore 24 Md**
d. DATE **MAY 31 '61**



1
FOR STATE
HEALTH DEPT.

TO DE. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5239

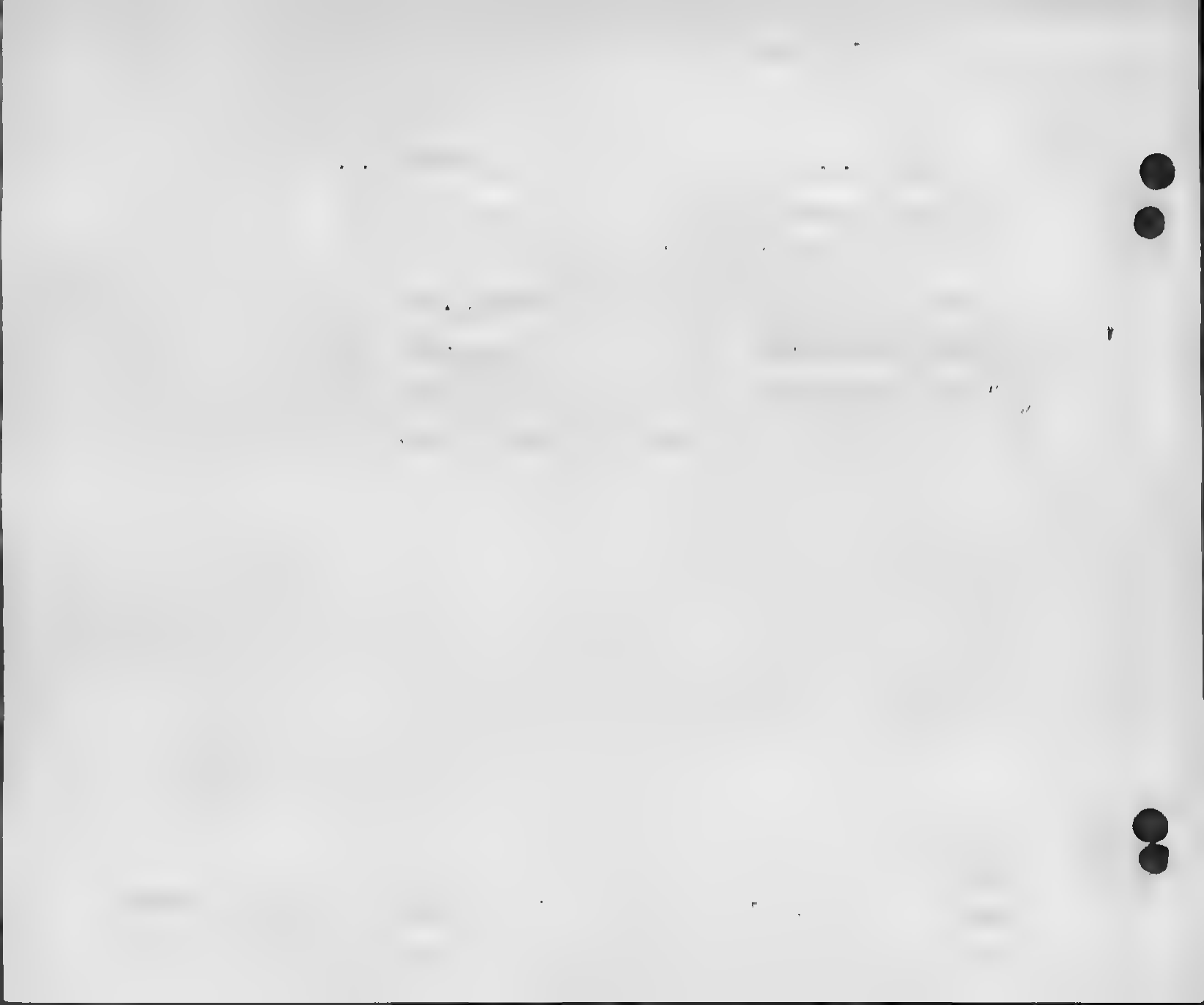
05231

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN if outside corporate limits write RURAL and give nearest town Phoenix P.O. c. LENGTH OF STAY IN IL d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Dance Mill Road		2. USUAL RESIDENCE Where and how lived if usual residence is on a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN if outside corporate limits write RURAL and give nearest town Phoenix P.O. d. STREET ADDRESS Dance Mill Road	
3. NAME OF DECEASED (Type or print) John Watkins Grafton 4. SEX Male 5. COLOR OR RACE White 6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> May 27, 1873 7. DATE OF BIRTH 87 8. AGE in years 87 9. DATE OF DEATH May 9, 1961 10. OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad man-retired Clerk 11. BIRTH PLACE (State or foreign country) Maryland USA 12. MOTHER'S M A DEN NAME Elizabeth Varnes		13. FATHER'S NAME Ralph Lee Grafton 14. SOCIAL SECURITY NO. None 15. INFORMANT Family Records 16. WA. DE. EX. ED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) None 17. CAUSE OF DEATH [Enter only one cause pastime for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (b) DUE TO (c) DUE TO Coronary Occlusion Sudden Hypertensive Cardia Renal Vascular Disease 18. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, etc.) 19. TIME OF INJURY (Hour, m., p.m.) 19 20. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> I kept <input type="checkbox"/> death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Indeterminate manner <input type="checkbox"/> ACTUAL SIGNATURE Charles F. Howard EXAMINER'S NAME 22a. BURIAL (CREMATION) 22b. DATE THEREOF Burial May 12, 1961 23. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland 24a. NAME OF CEMETERY OR CREMATORY Old Brick Baptist Cemetery 24b. LOCATION (City, town, or county) Jarrettsville, Maryland 25. REC'D BY REG. STRAR May 15 '61 26. REGISTRAR'S SIGNATURE Charles F. Howard	

MEDICAL CERTIFICATION

PERFORMED?
YES ☒ NO ☐

DATE SIGNED
5/11/61



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5240

CERTIFICATE OF DEATH

15232

1. PLACE OF DEATH
a. COUNTY **Baltimore** b. CITY OR TOWN **Baltimore** c. LENGTH OF STAY IN 1b **2 DAYS**
d. NAME OF HOSPITAL OR INSTITUTION **Veterans Administration Hospital**

2. USUAL RESIDENCE (Where deceased lived in structure for 1 year or longer)
a. STATE **Maryland** b. COUNTY **Baltimore** c. CITY OR TOWN **Baltimore** d. STREET ADDRESS **3627 Chesterfield Avenue**

3. NAME OF DECEASED **Vincent -- GRANDE SR**
First Middle Last
4. DATE OF DEATH **May 3, 1961**
Month Day Year
5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH **December 26, 1896**
Month Day Year
9. AGE (in years, last birthday) **64** yrs
10. a. USUAL OCCUPATION **Bricklayer (Retired)** b. KIND OF BUSINESS OR INDUSTRY **Self Employed** c. PLACE OF BIRTH **St Marie Italy**
11. CITIZEN OF WHAT COUNTRY **U.S.A.**
12. CITIZEN OF WHAT COUNTRY **U.S.A.**
13. FATHER'S NAME **Ottavio Grande** 14. MOTHER'S MAIDEN NAME **Carmella Pitgetcor**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? **Yes** 16. SOCIAL SECURITY NO. **217-22-2262** 17. INFORMATION **Clin. Rec., VAH, Baltimore, Md-Ft Howard Div.**
(Yes, no, or unknown) (If yes, give war/branch of service)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE a. **CARDIAC ARRHYTHMIA**
b. **ARTERIOSCLEROTIC HEART DISEASE**
c. **UNKNOWN**
DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? **YES** ☐ **NO** ☒
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town, County, State)

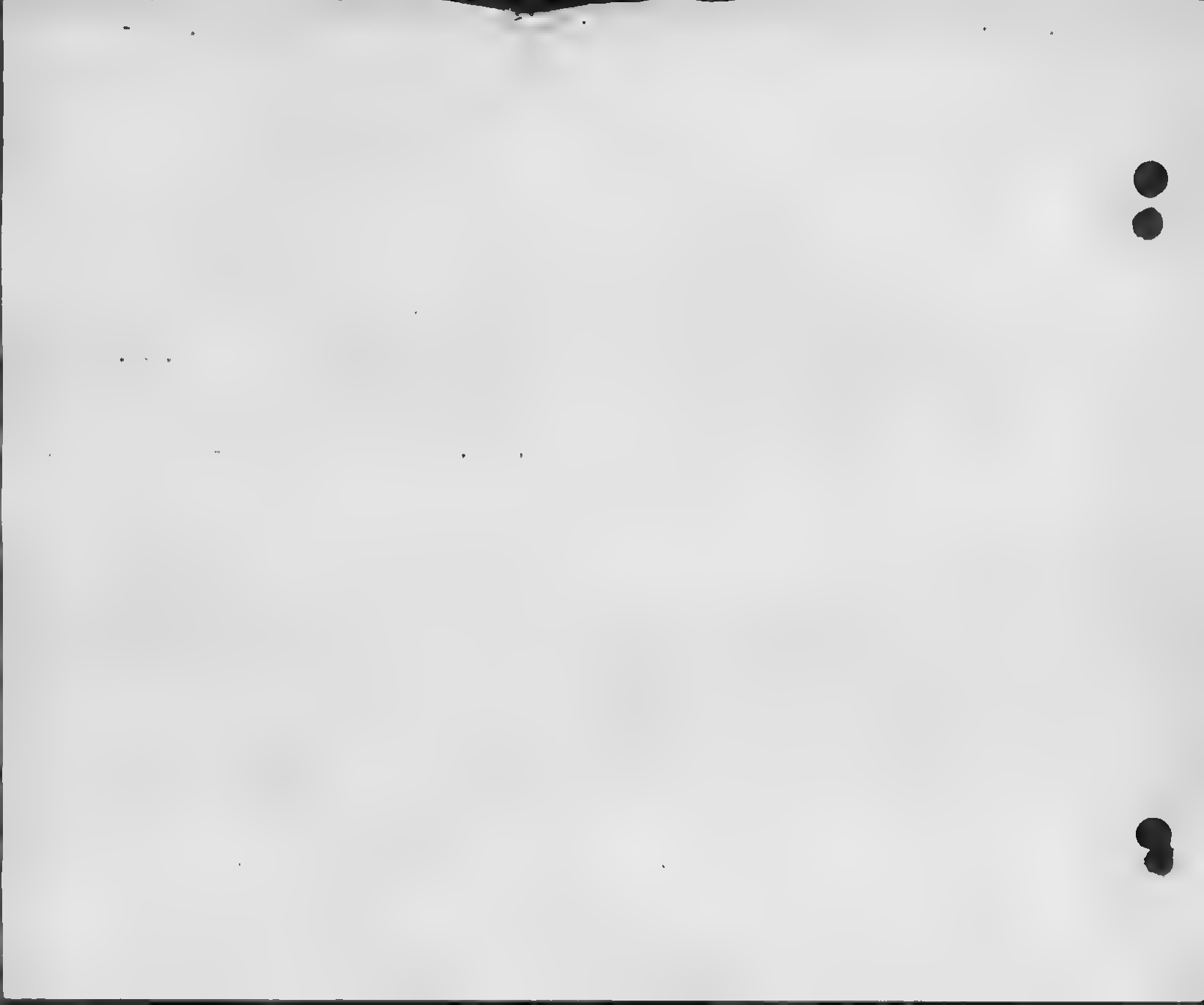
21. I certify that ☒ (this hospital) attended the deceased from **May 1, 1961** to **May 3, 1961**, that ☒ (we) last saw the deceased alive on **May 3, 1961**, and that death occurred at **5:40 p.m.** from the causes and on the date stated above.
22a. SIGNATURE **Thomas F. Crahan** M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED **5/4/61**
22c. PHYSICIAN'S NAME (Type) **THOMAS F. CRAHAN, M.D.** 22d. ADDRESS **VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **5/8/61** 23c. NAME OF CEMETERY OR CREMATORY **Holy Redeemer Cemetery** 23d. LOCATION (City, town or county) **Baltimore, Maryland**
24. FUNERAL DIRECTOR'S SIGNATURE **Schimunek Funeral Home** ADDRESS **3331 Brehm's Lane Baltimore 13, Md** 25a. REC'D BY REGISTRAR **DATE MAY 9 '61** 25b. REGISTRAR'S SIGNATURE **Arthur L. Thomas**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1 FOR STATE HEALTH DEPT.

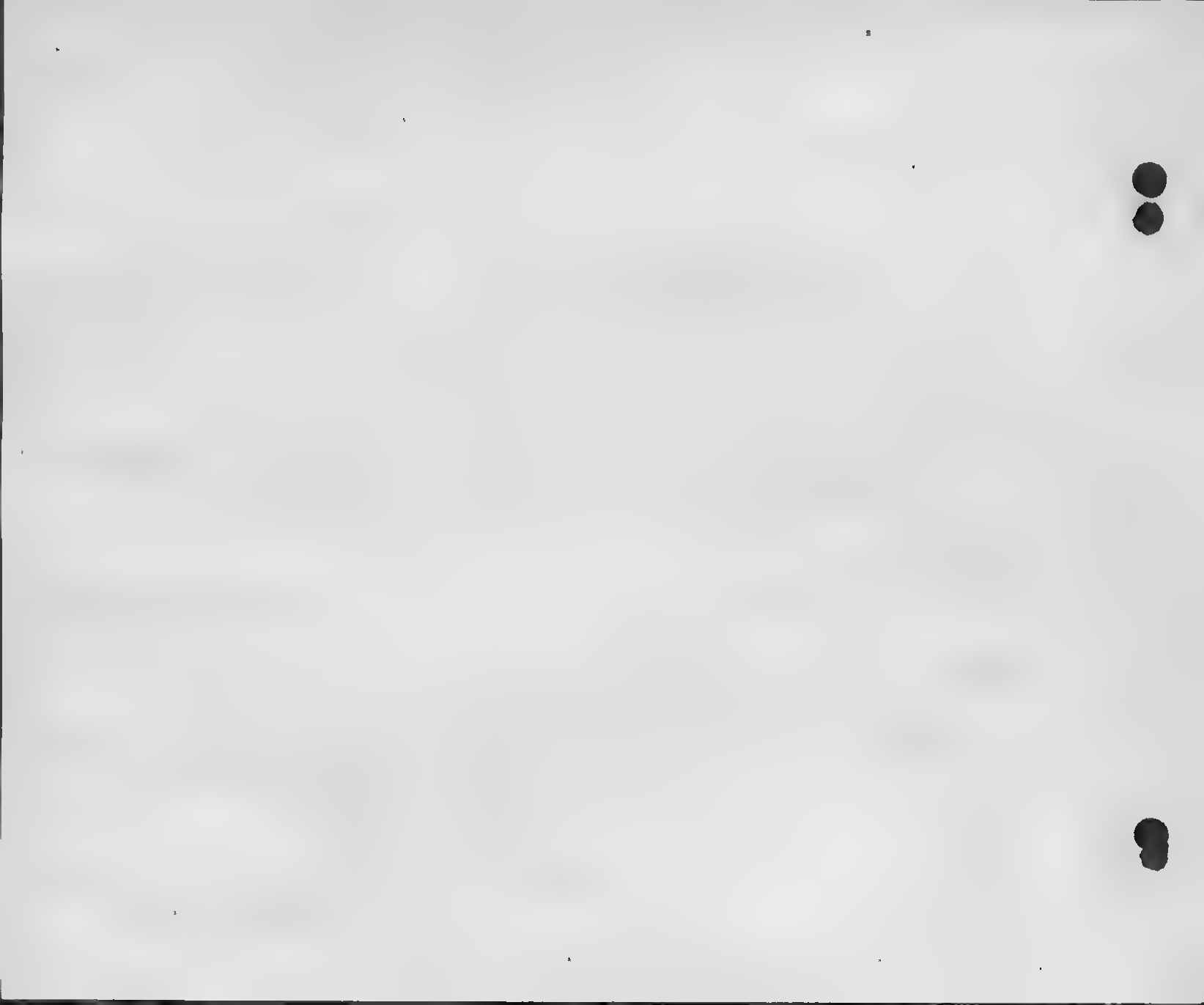
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05238

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bainville</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1611 Naturo Road</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, R. residence bldg., admission) a. STATE <u>Ind.</u> b. COUNTY <u>Ind.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bainville</u> d. STREET ADDRESS <u>1611 Naturo Road</u>			
3. NAME OF DECEASED (Type or print) <u>John</u> 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1961</u> 9. AGE (in years last birthday) <u>68</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8. DATE OF BIRTH <u>1-18-1893</u> 13. FATHER'S NAME <u>William Tegeler</u> 14. MOTHER'S MAIDEN NAME <u>Mary Eckle</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>216104121</u> 17. INFORMANT <u>William W. Granlund 1027 Glenview Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> <u>Stroke</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Diabetic Mellitus</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>20 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u></u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a.m. <u>19</u> Mon h Day Year p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles F. Huns</u> EXAMINER'S NAME (Type) <u>Charles F. Huns</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>5/31/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6/5/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery, Baltimore, Ind.</u>			
23. FUNERAL DIRECTOR <u>Leonard J. Ruck 5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Huns</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No

05234

1. PLACE OF DEATH
a. COUNTY

BALTO.

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL - BALTO

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

a. STATE Maryland b. COUNTY Balto.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Balto.

d. STREET ADDRESS

7910 Aiken Balto 6.

YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

First Middle Last
Helen M. GRAVES

4. DATE OF DEATH

Month Day Year
MAY 8 1961

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

MAR 13, 1892

9. AGE in years (last birthday)

69 yrs

IF UNDER 15, IF UNDER 24, IF 24-44, IF 45-64, IF 65-74, IF 75-84, IF 85-94, IF 95-104

Months Days Hours Mins

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

PENNA

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

JOHN PARK

14. MOTHER'S M A DEN NAME

MARY EISENHOWER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

NO

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

MRS NICHOLAS STONE 7910 AIKEN AVE

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

Atherosclerotic Hypertensive Cardiovascular

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Dissect

undist.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY

Month, Day, Year

Hour a. m. p. m.

19

20d. INJURY OCCURRED

While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE

John C. Hyle

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

John C. Hyle

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

5-8-61

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

5/11/61

22c. NAME OF CEMETERY OR CREMATORY

MCRELAND MEM.

22d. LOCATION (City, town, or county)

BALTIMORE, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE

Wm Cook - Blight, Inc 6009 Harford Rd.

24a. REC'D BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used at a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

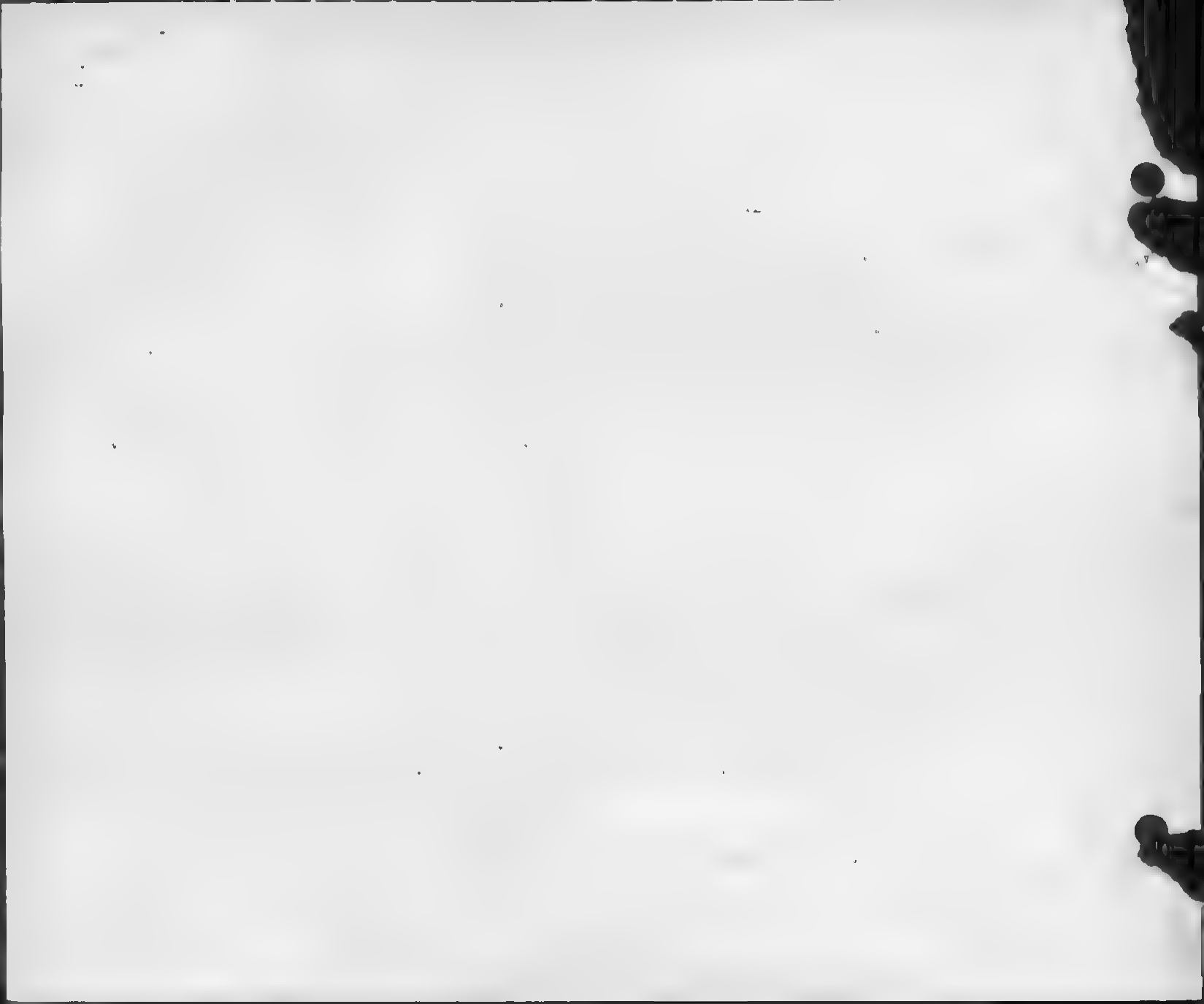
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05235

5243

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (For outside corporate limits, write RURAL and give nearest town) Baltimore 7				c. LENGTH OF STAY IN 1b 8 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4010 Buckingham Rd.				e. STREET ADDRESS 4010 Buckingham Road			
3. NAME OF DECEASED (Type or print) First Middle Last Mr. Herbert E Green				4. DATE OF DEATH Month Day Year May 20 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 3, 1875	
9. AGE (in years last birthday) 84 yrs		F UNDER 1 YEAR Months Days		F UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Ice & Fuel Co				10b. KIND OF BUSINESS OR INDUSTRY Ice & Fuel Bus.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edward J. Green				14. MOTHER'S MAIDEN NAME Sophia Peddicord			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO			
17. INFORMANT Address Mrs. Alma C. Green, 4010 Buckingham Rd. Baltimore 7,							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer - Carcinoma of Colon							
DUE TO (b) Broncho - Pneumonia							
DUE TO (c) Arterio - Sclerotic Heart Disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I							
19. Was AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				20g. (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Feb. 14, 1961 to May 20th, 1961 that (I) (we) last saw the deceased alive on May 20, 1961 and that death occurred at 5:30 P. from the causes and on the date stated above							
22a. SIGNATURE Earl L. Chambers				22b. DATE SIGNED May 20, 1961			
22c. PHYSICIAN'S NAME (Type) Dr. Earl Chambers				22d. ADDRESS 4108 Liberty Rd. Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/23/61		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City, town, or county) State Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Henry Dyer				25. REC'D BY REGISTRAR MA 20 61		25b. REGISTRAR'S SIGNATURE	
ADDRESS 8728 Liberty Rd. Randallstown, Md.							

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death by the attending physician and completely filed by the funeral director. After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5244

05238

1 PLACE OF DEATH
a. COUNTY **BALTIMORE** MARYLAND
b. CITY OR TOWN, (if outside corporate limits, write RURAL and give nearest town) **CATONSVILLE**
c. LENGTH OF STAY IN b **3 YEARS**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **House in the Pines - 16 Fusting Ave**

2 USUAL RESIDENCE, Where deceased lived "last" Residence
a. STATE **MARYLAND** b. COUNTY
c. CITY OR TOWN, (if outside corporate limits write RURAL and) **BALTIMORE**
d. STREET ADDRESS **McCabe Ave**

3 NAME OF DECEASED (Type or print)
First Middle Last **ELIZABETH K. GRIESMAN**

5 SEX **FEMALE** 6 COLOR OR RACE **WHITE** 7 MARRIED ☐ NEVER MARRIED ☒ 8 DATE OF BIRTH **JAN 15, 1874**
9 AGE (In years IF UNDER 1 YEAR IF UNDER 2 HRS last birthday) **87** yrs Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired **TAX CLERK** 10b. KIND OF BUSINESS OR INDUSTRY **CITY GOVERNMENT** 11. BIRTHPLACE **BALTIMORE, MD.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **THEODORE GRIESMAN** 14. MOTHER'S MAIDEN NAME **KUNIGUNDA KROLL**

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO **No** 17. INFORMANT **Mrs. Russell Hicks** Address **215 GORDALE RD BALT MD.**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Myocardial Infarction**
DUE TO
Conditions (b) which gave rise to immediate cause (a), stating the underlying cause last. **Arteriosclerotic Cardio-Vascular Disease**
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACIDENT WAS UNDERLYING OR CONTRIBUTING () CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 **8-15-1958**
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. City or town, (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **8-15-1958** to **5-10-1961** that (I) (we) last saw the deceased alive on **5-9-1961**, and that death occurred at **6 P.M.** from the causes and on the date stated above

22a. SIGNATURE **Wilmer K. Gallagher** M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED **5/11/61**
22c. PHYSICIAN'S NAME (Type) **Wilmer K. Gallagher, M.D.** 22d. ADDRESS **6209 Frederick Ave, Baltimore 28, Md.**

23a. BURIAL, CREMATION REMOVAL (Specify) **BURIAL** 23b. DATE THEREOF **MAY 12, 1961** 23c. NAME OF CEMETERY OR CREMATORY **BALTIMORE CEMETERY** 23d. LOCATION (City, town or co., city) (State) **BALTIMORE, MARYLAND**

24. FUNERAL DIRECTOR'S SIGNATURE **HENRY W. JENKINS & Sons** ADDRESS **4905 YORK RD. BALT 12, MD.** 25a. REC'D BY REG. STRAR **MAY 12 '61** 25b. REGISTRAR'S SIGNATURE **Charles S. Frank**

TO HO OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



05237

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN lb 41 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3111 Ardee Way		d. STREET ADDRESS 3111 Ardee Way		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARGARET		First ANN		Middle GUNTER	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Feb. 11, 1883		9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR Months 9 Days 9 Hours 19 Min 61	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		12. KIND OF BUSINESS OR INDUSTRY At home		13. BIRTHPLACE (State or foreign country) Pennsylvania	
14. FATHER'S NAME Patrick L. Davis		15. MOTHER'S MAIDEN NAME Mary Connelly		16. CITIZEN OF WHAT COUNTRY? U.S.A.	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No.		18. SOCIAL SECURITY NO. No.		19. INFORMANT Mrs. Joseph Hunter 3111 Ardee Way-22	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Artery Disease		21. INTERVAL BETWEEN ONSET AND DEATH 7 days		22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None		24. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25a. TIME OF INJURY Month, Day, Year Hour a. m. 11 p. m. 19		25b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		26. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
27. CITY or town Dundalk		28. (County) Baltimore		29. (State) Md.	
30. I certify that I attended the deceased from Dec 29, 1959 to May 9, 1961 , that I last saw the deceased alive on May 8, 1961 , and that death occurred at 10:30 M, from the causes and on the date stated above.		31. ADDRESS (Street, city or town, state) 3111 Ardee Way, Baltimore, Md.		32. DATE SIGNED 5/11/61	
33. ACTUAL SIGNATURE M.B. Davis		34. PHYSICIAN'S NAME (Type) M.B. Davis, M.D.		35. SIGNATURE OF REGISTRAR John A. Hunter	
36. BURIAL CREMATION Burial		37. DATE THEREOF 5/12/61		38. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
39. LOCATION (City, town, or county) Colgate, Md.		40. (State) Md.		41. REC'D BY REGISTRAR May 15 '61	
42. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.		43. ADDRESS Ullrich Funeral Home Dundalk, Md.		44. REGISTRAR'S SIGNATURE John A. Hunter	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5246

CERTIFICATE OF DEATH

Reg. Dist No. 15238

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Court Road		2. USUAL RESIDENCE (Where deceased lived: f institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville d. STREET ADDRESS Old Court Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ESTHER Middle F. Last GUTMAN		4. DATE OF DEATH Month May Day 30 Year 1961	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9. AGE (In years lost birthday) 81 yrs 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 11. BIRTHPLACE (State or foreign country) Ohio 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ? Friedman		14. MOTHER'S MAIDEN NAME Fannie ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO no INFORMANT Mrs. Deane G. Newmeyer-1505 Pentridge Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Thrombosis - Arteriosclerosis 420.1 DUE TO (b) Old Coronary Thrombosis - Arteriosclerosis C. 40 years Conditions if any which gave rise to immediate cause (a) stating the underlying cause last (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part of item 18)	
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1955 to May 30 , 1961, that I last saw the deceased alive on May 30 , 1961, and that death occurred at 11 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Bernard J. Cohen M.D. ADDRESS (Street, city or town, state) The Maryland Apt - 351 St Paul PHYSICIAN'S NAME (Type) BERNARD J. COHEN - MD DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 31/61	22c. NAME OF CEMETERY OR CREMATORY Chizuk Amuno	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Sol. Levinson & Bros. Inc. 6010 Reisterstown Rd.		24a. REC'D BY REGISTRAR DATE JUN 1 '61	24b. REGISTRAR'S SIGNATURE Arthur L. Thomas

Page 4 death certificate be executed with n 24 by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial or cremation, or removal and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5247

CERTIFICATE OF DEATH

05239

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a STATE Maryland b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22		c LENGTH OF STAY IN 1b 20 yrs.	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1906 Tyler Road		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last FRANK JAMES HARKNESS		4 DATE OF DEATH Month Day Year May 11th, 19 61	
5 SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 27, 1888
9 AGE (In years last birthday) 72 yrs		10a IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10b USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Electrician		10c KIND OF BUSINESS OR INDUSTRY Mfg.	
11 BIRTHPLACE (State or foreign country) Tenn.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Frank Harkness		14 MOTHER'S M A DEN NAME Mary Coniff	
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) yes (If yes, give war or dates of service) WWI		16 SOCIAL SECURITY NO. 213-01-4258	
17 INFORMANT Lucy E. Harkness		Address same as #2	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO LEUKEMIA Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last Generalized A.S. DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Leukemia Arthritis		INTERVAL BETWEEN ONSET AND DEATH 6-8 days 5 years	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-5 , 19 54 , to 5-11 , 19 61 , that I last saw the deceased alive on 5-4 , 19 61 , and that death occurred at 6:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2 Kinship Road DATE SIGNED 5/12/61			
ACTUAL SIGNATURE Jack C. Collins		M.D. 2 Kinship Road	
PHYSICIAN'S NAME (Type) Jack C. Collins, M.D.		Baltimore 22, Maryland	
22a BURIAL, CREMATION, REMOVAL (Specify) Burial	22b DATE THEREOF 5/13/61	22c NAME OF CEMETERY OR CREMATORY Moreland Memorial	22d LOCATION (City, town, or county) (State) Baltimore, Maryland
23 FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc.		24a REC'D BY REGISTRAR MAY 15 61	
ADDRESS Dundalk 22, Md		24b REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05240

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2115 OAKLAND AVE.</u>		d. STREET ADDRESS <u>2115 OAKLAND AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>MULLIN</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 4, 1897</u>
9. AGE (In years last birthday) <u>63</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Duke</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA (UNKNOWN)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MR Jewel C HART-Stephens Dr.</u>		Address <u>1136</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u> </u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u>61</u> , that I last saw the deceased alive on <u> </u> , 19 <u>61</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u> </u> MD		ADDRESS (Street, city or town, state) DATE SIGNED <u> </u>	
PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/6/61</u>	22c. NAME OF CEMETERY OR CHURCH <u>SENIOR BAPTIST Church</u>	22d. LOCATION (City, town, or county) (State) <u>N.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>LEONARD J. RUCK</u>		24a. REC'D BY REGISTRAR DATE <u>4 '61</u>	24b. REGISTRAR'S SIGNATURE <u> </u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05241

1. PLACE OF DEATH
a. COUNTY **Baltimore** b. CITY OR TOWN **Fort Howard** c. LENGTH OF STAY IN 1b **15 days**
d. NAME OF HOSPITAL OR INSTITUTION **Veterans Administration Hospital**

2. USUAL RESIDENCE (Where deceased lived 1 month or more prior to death)
a. STATE **Maryland** b. COUNTY **Baltimore** c. CITY OR TOWN **Baltimore 23** d. STREET ADDRESS **928 W. Franklin Street**

3. NAME OF DECEASED (Type or print)
First **HENRY** Middle **- - -** Last **HAWKS**

4. DATE OF DEATH
Month **May** Day **12** Year **1961**

5. SEX **Male** 6. COLOR OR RACE **Negro** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **March 15, 1898** 9. AGE (In years, months, days)
Years **63** Months **0** Days **0**

10. USUAL OCCUPATION, (If deceased was engaged in a business, profession, or occupation during most of working life, even if retired, state it)
Tool Keeper 11. KIND OF BUSINESS OR INDUSTRY **Aberdeen Proving Grds. Wilson, Virginia** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Henry Hawks** 14. MOTHER'S MAIDEN NAME **Mary Washington**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? **Yes** 16. SOCIAL SECURITY NO. **218-05-2726** 17. INFORMANT **Clinical Records VAH Baltimore**

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE **BRONCHOPNEUMONIA, EARLY**
CONGESTIVE HEART FAILURE
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO **UNKNOWN**

ART. II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO CAUSE OF DEATH (If not related to the terminal disease, condition given in Part I)
Nephrosclerosis - Unknown

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)
NO 20b. DESCRIBE HOW INJURY OCCURRED (Enter date of injury in Part I of Item 18)

20c. TIME OF INJURY Month Day Year **April 27 6:30 1961** 20d. INJURY OCCURRED **While at work** 20e. PLACE OF INJURY (Factory, street, office bldg., etc.) **VAH Baltimore Md - Ft Howard Division**

21. I certify that (X) (this hospital) attended the deceased from **April 27 6:30 1961** to **May 12 1961** and that death occurred at **P.M.** from the causes and on the date stated above.

22. SIGNATURE OF PHYSICIAN **Jack C. Lewis M.D.** 22b. DATE SIGNED **5-13-61**

23a. BURIAL CREMATION **Burial** 23b. DATE THEREOF **May 12 1961** 23c. NAME OF CEMETERY OR CREMATORY **Baltimore National** 23d. LOCATION (City, town or county, State) **Baltimore Maryland**

24. FUNERAL DIRECTOR'S SIGNATURE **Elroy O Wilson** 25a. REC'D BY REGISTRAR **VAH Baltimore Md - Ft Howard Division** 25b. REGISTRAR'S SIGNATURE

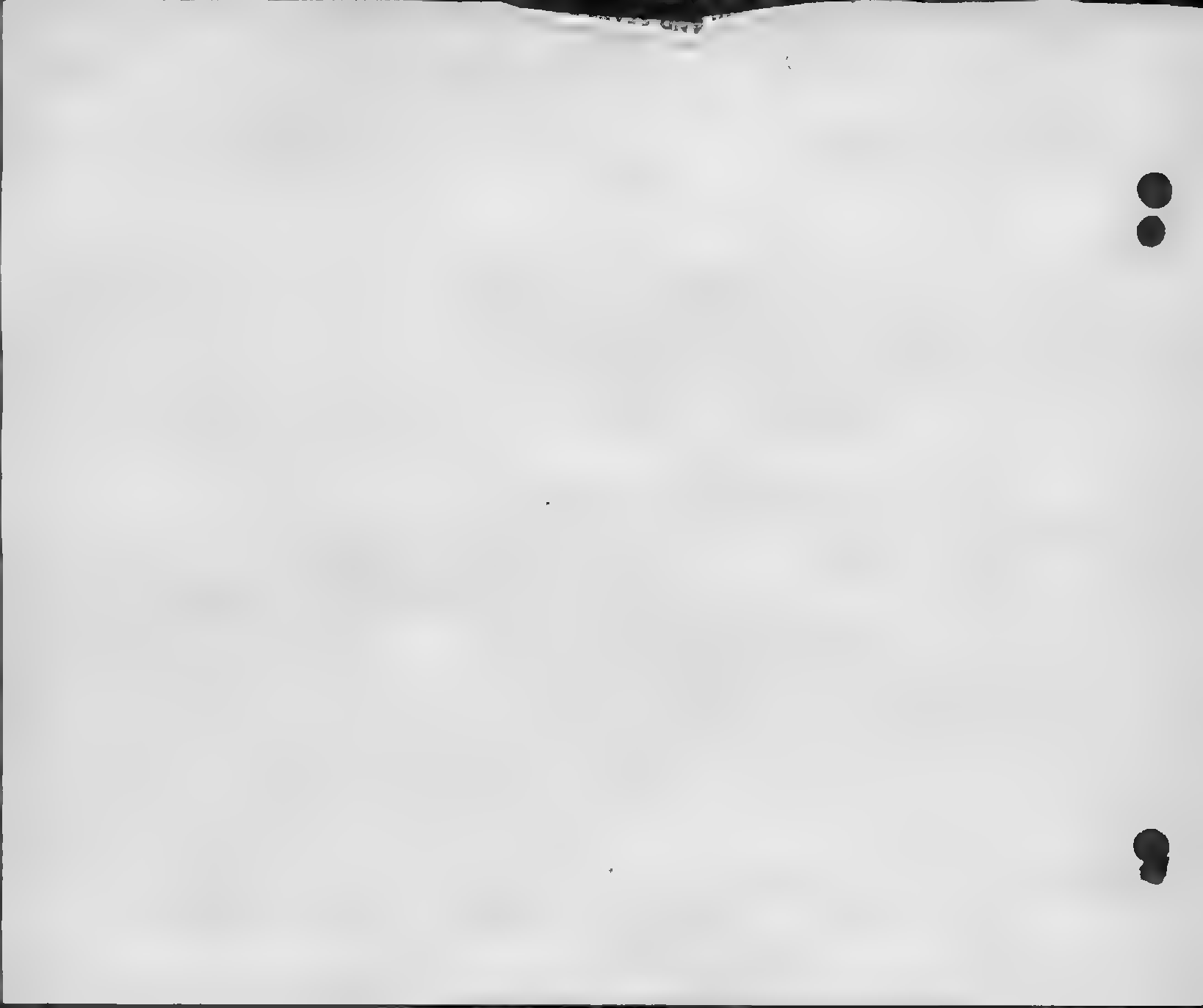
1

24 hours after death, the law requires that the death certificate be executed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05242

5250

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived) a. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>287 Hillcrest Ave</u>		d. STREET ADDRESS <u>287 Hillcrest Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Christina E. Heatterich</u>		4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1961</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 12 1878</u>
9 AGE (In years lost birthday) <u>82</u> yrs		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11 BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNK Blankford</u>		14 MOTHER'S MAIDEN NAME <u>ANNA BOOBERT</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>None</u>	
17 INFORMANT <u>Homer Foxworth Heatterich</u>		Address <u>287 Hillcrest Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-vascular renal</u> <u>14 x</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19. W.A.A. TOPSY PERF. ARMED YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>none</u>	
20c TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Mar 31 1960</u> to <u>May 3 1961</u> that (I) (we) last saw the deceased alive on <u>May 2 1961</u> , and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above			
22a SIGNATURE <u>G. M. Bacon</u>		22b DATE SIGNED <u>5/3/61</u>	
22c PHYSICIAN'S NAME Type <u>A. M. BACON</u>		22d ADDRESS <u>17 W. Bacon St. 10 Taylor Ave</u>	
23a BURIAL CREMATION REMOVAL (Specify) <u>buried</u>		23b DATE THEREOF <u>May 8 61</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>		23d LOCATION (City town or cemetery) <u>Taylor Ave</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Engelke</u>		25a REC'D BY REGISTRAR <u>May 5 '61</u>	
ADDRESS <u>11012 Blair Rd.</u>		25b REGISTRAR'S SIGNATURE	

Page 4 of 4
death certificate be executed within 24 hours after death.
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO HOSPITAL: This certificate may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

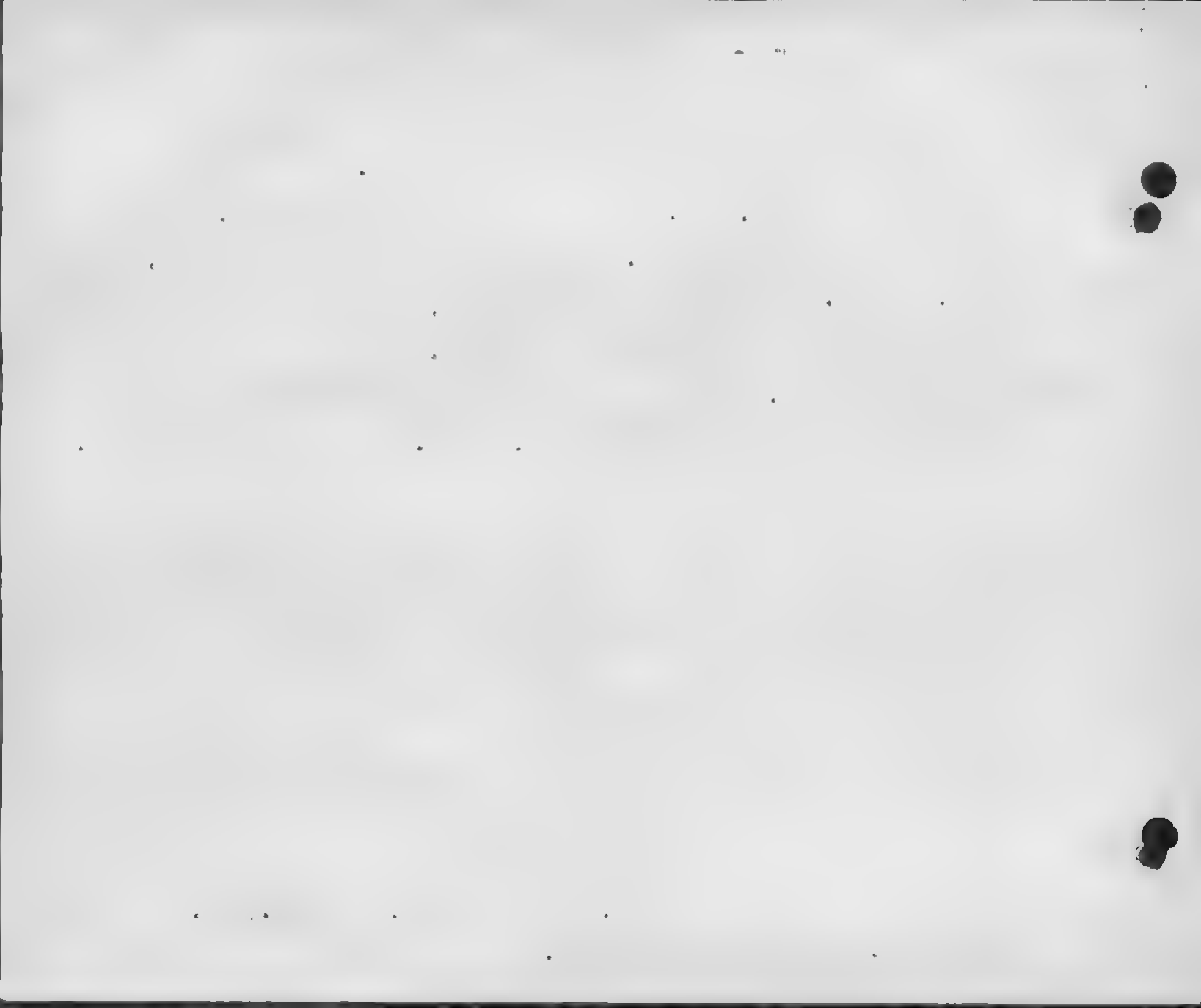
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

5251

05243

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived if not usual residence a. b. c. d. e. f. g. h. i. j. k. l. m. n. o. p. q. r. s. t. u. v. w. x. y. z.) a. STATE Md b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 4553 Pen Lucy Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Ridgeway Manor Nurs. Home.		d. STREET ADDRESS 4553 Pen Lucy Rd.	
3. NAME OF DECEASED (Type or print) First John Middle M. Last Hefner		4. DATE OF DEATH Month May Day 27 Year 1961	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1898
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired Stock Clerk		9. AGE (In yrs. if under 1 year, if over 1 year, last birthday) Months Days Hours Min. 63 yrs	
10b. KIND OF BUSINESS OR INDUSTRY Muth Bros.		11. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew F. Hefner		14. MOTHER'S MAIDEN NAME Catherine Schmidt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> If yes, no. & rank, & type of service, & dates of service W W 1		16. SOCIAL SECURITY NO. 1 217-26-2714 Mr. John F. Hefner, 4553 Pen Lucy Rd.	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE a. Cor pulmonale 27.1 DUE TO Longstanding & advanced emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Arteriosclerosis cardiovascular disease. Anemia, due to duodenal ulcer PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH b. NOT RELATED TO THE TERMINAL DISEASE c. d. e. f. g. h. i. j. k. l. m. n. o. p. q. r. s. t. u. v. w. x. y. z.		19. W. A. I. T. P. Y. PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. TIME OF INJURY Hour a.m. 19 p.m.		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. TIME OF INJURY Month Day Year May 27 1961		20d. CITY OR TOWN Balto.	
21. I certify that (I) (this hospital) attended the deceased from 30 Oct 1960 to 27 May 1961, that (I) () saw the deceased alive on 26 May 1961, and that death occurred at 12 PM , from the causes and on the date stated above.		22a. SIGNATURE Emil H. Henning Jr M.D. 22b. ADDRESS 601 W. Main St. Balto. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 31/61	
23c. NAME OF CEMETERY OR CREMATORY Balto. National Cemty.		23d. LOCATION (City, town or county) Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke Fun. Dir. 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR DATE MAY 31 1961	
25b. REGISTRAR'S SIGNATURE Arthur L. Krause		25c. REGISTRAR'S SIGNATURE Arthur L. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

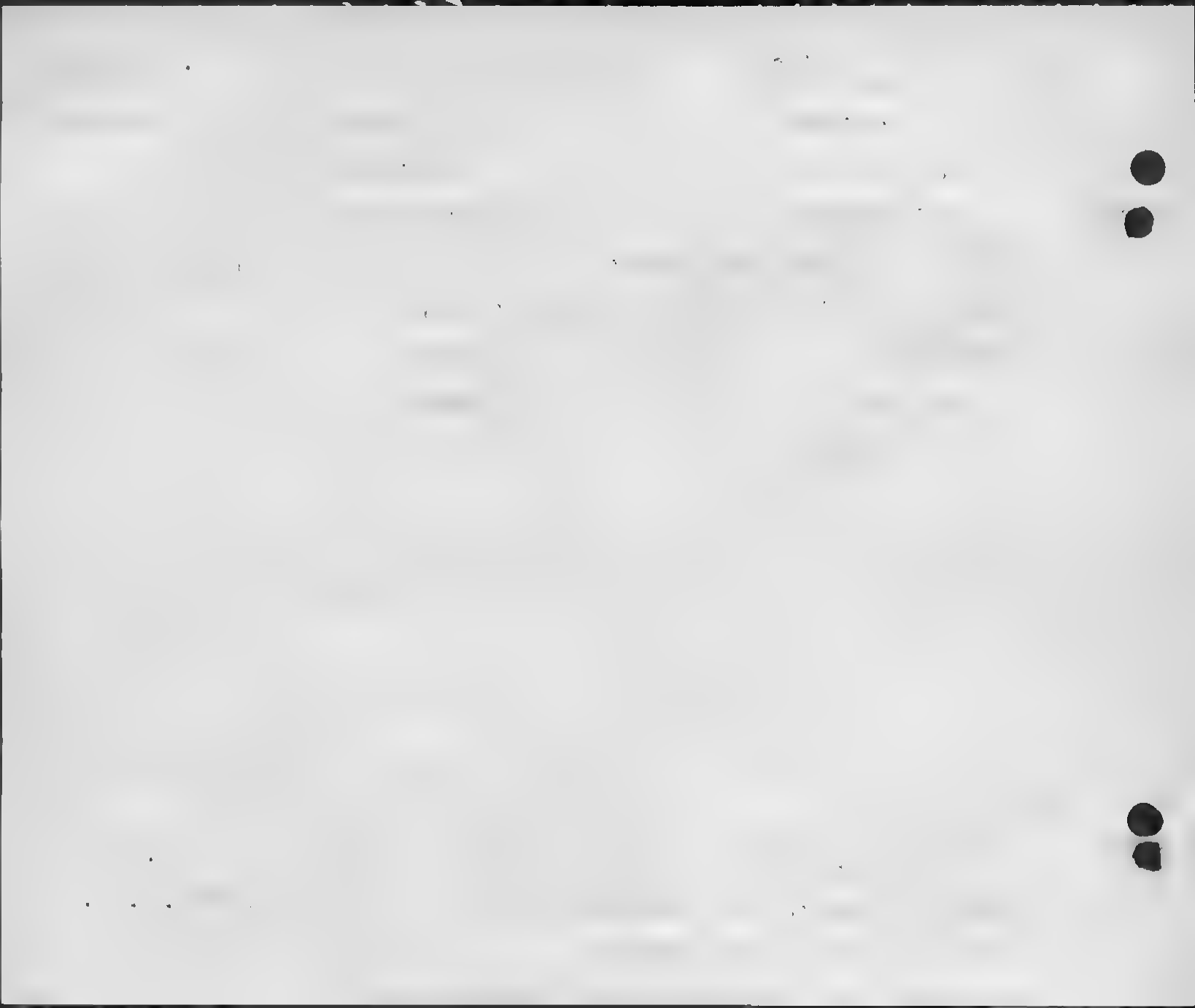
5252

05244

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE Where deceased lived at time of death a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN, if outside corporate limits write RURAL and give nearest town Parkville 14		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkville 14	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 9111 Lamaze Road		e. STREET ADDRESS 9111 Lamaze Road	
3. NAME OF DECEASED (Type or print) LAURA SIMMS HEUBECK		f. DATE OF DEATH Month May Day 23 , Year 1961	
4. SEX Female	5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH January 23, 1897
8. AGE (In years, last birthday) 64 yrs		9. IF UNDER 1 YEAR, IF UNDER 1 YEAR, IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. KIND OF BUSINESS OR INDUSTRY Own Home	
12. CITIZENSHIP USA		13. FATHER'S NAME James Simms	
14. MOTHER'S MAIDEN NAME Luella ?		15. WAS DECEASED EVER IN U.S. ARMED FORCES? No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Family Records	
18. CAUSE OF DEATH (Enter only one cause part (a) or (b) and (c)) PART A. DEATH WAS CAUSED BY IMMEDIATE CAUSE a. Carcinoma of rectum b. 1-7 X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. 1-7 X DUE TO PART B. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART A. None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part B of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town Baltimore	
21. I certify that (I) (this hospital) attended the deceased from 6/15 , 19 49 to 5/23 , 19 61 , that (I) (we) last saw the deceased alive on... 19 ... and that death occurred at... M , from the causes and on the date stated above.			
22a. SIGNATURE <i>Edw. Gordon Gran</i>		22b. DATE SIGNED 5/24/61	
22c. PHYSICIAN'S NAME (Type) Edw. Gordon Gran, M.D.		22d. ADDRESS 8523 Loch Raven Blvd, Balto. 4, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 26, 1961	
23c. NAME OF CEMETERY OR CREMATORY Providence Cemetery		23d. LOCATION (City, town or county) Providence, Balto. Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		25. REC'D BY REGISTRAR MAY 31 1961	
25a. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5253

65245

1. PLACE OF DEATH

a. COUNTY

Baltimore

Co. MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Monrovia

c. LENGTH OF STAY IN TOWN

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

100 West 10th

3. NAME OF DECEASED

(Type or print)

HARRY C. HOBBS

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH

5/24/175

9. AGE (In years)

86 yrs

IF UNDER 1 YEAR IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City & State)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c)

PART I. DEATH WAS CAUSED BY:

(a) DUE TO
(b) DUE TO
(c) DUE TO

*Cardiovascular Collapse
General Atherosclerosis*

INTERVAL BETWEEN ONSET AND DEATH

*2 days
20 years*

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY (Hour, e.m., p.m.)

20d. INJURY OCCURRED (While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from *Jan 1961* to *5/14/61* that (I) (we) last saw the deceased alive on *5/14/61* and that death occurred at *12:30 PM* from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

ATTENDING PHYS.

MED. DIRECTOR ☒

STAFF PHYS. ☐

22b. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE *MAY 18 '61*

Arthur J. ...



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled out by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

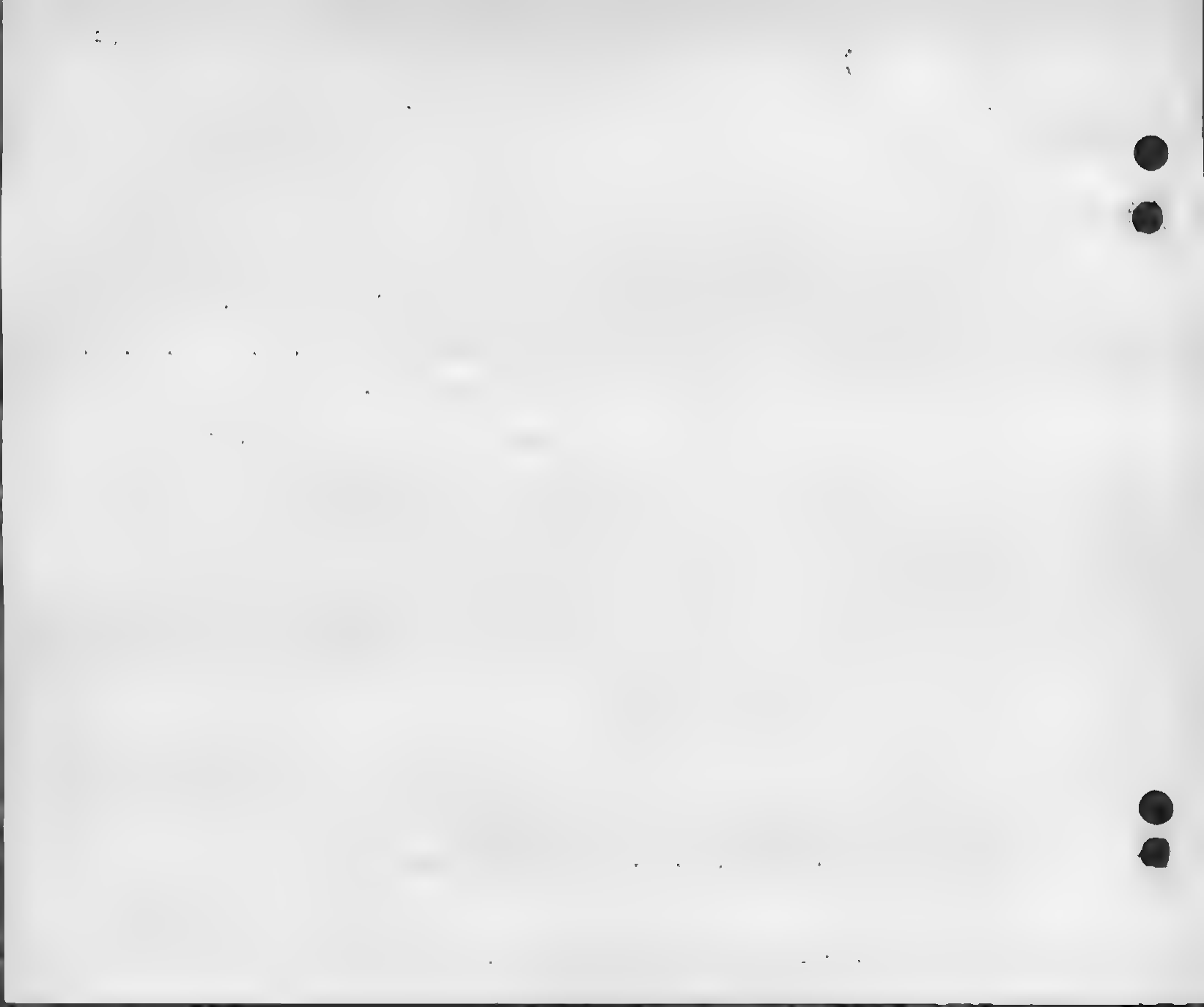
CERTIFICATE OF DEATH

Reg. Dist. No.

05246

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SATURNVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
c. LENGTH OF STAY IN 1b <u>4 YEARS</u>		d. STREET ADDRESS <u>423 EAST ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CATON RIDGE NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>KENDALL</u> Last <u>HOOPER</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>28</u> Year <u>1961</u>	
5. SEX <u>F. M.</u>	6. COLOR OR RACE <u>W.H.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/3/1874</u>
9. AGE (In years last birthday) <u>86</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRESSMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GEORGE HOOPER</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH HENRY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>MRS. FANNIE YOST</u>		Address <u>423 EAST ST. BAL.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio sclerosis general</u> (c) <u>hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Intermittent</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia - Bacterial</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7:15</u> , 19 <u>61</u> , to <u>May 28</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>May 22</u> , 19 <u>61</u> , and that death occurred at <u>11:30</u> AM, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Cliff Ratliff</u> M.D.		ADDRESS (Street, city or town, state) <u>4605 S. MONMOUTH AVE</u>	
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR</u>		BALTIMORE 29, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-30-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WAKER HILL</u>	22d. LOCATION (City, town, or county) (State) <u>BUNKER HILL</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Bacon</u>		ADDRESS <u>Martinsburg, W. Va.</u>	
24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>CLIFF RATLIFF</u>	





Page 4
TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. The attending physician or attending physician an- may be required to sign the certificate. The funeral director, after this certificate has been signed by the attending physician and completely filled out, should detach page 3 and 4 and file them with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA AIS (4)
15M 9 59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5256

05248

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission on a STATE Maryland b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c LENGTH OF STAY IN 1b 12 yrs.	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1322 Ridge Road		e STREET ADDRESS 1322 Ridge Road	
3 NAME OF DECEASED (Type or print) First Middle Last Charles William Hundertmark Sr.		4. DATE OF DEATH Month Day Year May 16, 1961	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 12, 1890
9 AGE (in years last birthday) 70 yrs		F UNDER 1 YEAR: F UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab driver		10b KIND OF BUSINESS OR INDUSTRY Transporting people	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME Frederick Hundertmark		14 MOTHER'S MAIDEN NAME Elizabeth	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO. 212-03-0969A	
17 INFORMANT Mrs. Clara Leonard		Address 1322 Ridge Rd. Catonsville 28 Md.	
18 CAUSE OF DEATH [Enter on any one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Hypertensive arteriosclerosis of brain DUE TO (c) 14 years of hypertension CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day Year Hour a m p m 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from May 2, 1961 to May 16, 1961 that (I) (we) last saw the deceased alive on May 16, 1961 and that death occurred at 7:00 AM from the causes and on the date stated above			
22a SIGNATURE John F. Coolahan M. D.		22b DATE SIGNED 5/17/61	
22c PHYSICIAN'S NAME (Type) John F. Coolahan M. D.		22d ADDRESS 4201 WILKENS AVE. #1	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 5/19/1961	
23c NAME OF CEMETERY OR CREMATORY Loudon Park		23d LOCATION (City, town or county) State Baltimore, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE W. H. ...		25a REC'D BY REGISTRAR DATE MAY 23 1961	
25b REGISTRAR'S SIGNATURE Arthur S. ...			



CERTIFICATE OF DEATH

Reg. Dist. No.

05249

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Towson</u> c LENGTH OF STAY N 1b <u>2 yrs</u> d NAME OF HOSPITAL (If not a hospital give street address) OR INSTITUTION <u>Agnes Meyer & Leaman Home</u>		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u> c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Baltimore</u> d STREET ADDRESS <u>3965 North Charles St</u> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>P.</u> Last <u>Hyde</u>		4 DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1941</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 21, 1894</u>
9 AGE (in years last birthday) <u>47</u> yrs		10 F UNDER 1 YEAR Months <u>1</u> Days <u>5</u> Hours <u>5</u> Mins <u>5</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Childs Nurse</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
11 BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Richard Hyde</u>		14 MOTHER'S MAIDEN NAME <u>Anna Gorman</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO <u>---</u>	
INFORMANT <u>Louise Hamerton, R.N.</u>		Address <u>---</u>	
17 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage, acute</u> DUE TO <u>391X</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost <u>Previous C-U-A.</u> DUE TO <u>Hypertensive Arteriosclerotic Vascular Disease</u> (c) <u>3 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 yrs</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 17			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month <u>May</u> Day <u>5</u> Year <u>1941</u> Hour <u>3:30</u> p. m.		20d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1938</u> to <u>May 5</u> , 1941, that I last saw the deceased alive on <u>May 5</u> , 1941, and that death occurred at <u>3:30 a.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Newland Edward Dey</u> M.D.		ADDRESS (Street, city or town, state) <u>4-E-33rd St Baltimore Md</u>	
PHYSICIAN'S NAME (Type) <u>Newland Edward Dey, M.D.</u>		DATE SIGNED <u>May 5, 1941</u>	
22a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b DATE THEREOF <u>5-5-41</u>	
22c NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS</u>		22d LOCATION (City, town or county) (State) <u>ANNE ARUNDEL COUNTY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LIM BOOK INC 1217 5th St Baltimore Md</u>		ADDRESS <u>---</u>	
24a REC'D BY REGISTRAR <u>---</u>		24b REGISTRAR'S SIGNATURE <u>---</u>	

ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The attending physician and the funeral director, after this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT
M
I
CAL EXAMINER: This certificate should be executed within 24 hours after death. If a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the State Board of Health. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05250

1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville
c. LENGTH OF STAY IN b. 2 th 23 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Joseph's Hospital

2. USUAL RESIDENCE Where deceased lived. If institution, give name
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 2438 Dorton Court
e. IS RESIDENCE ON A FARM? ☒ YES ☐ NO

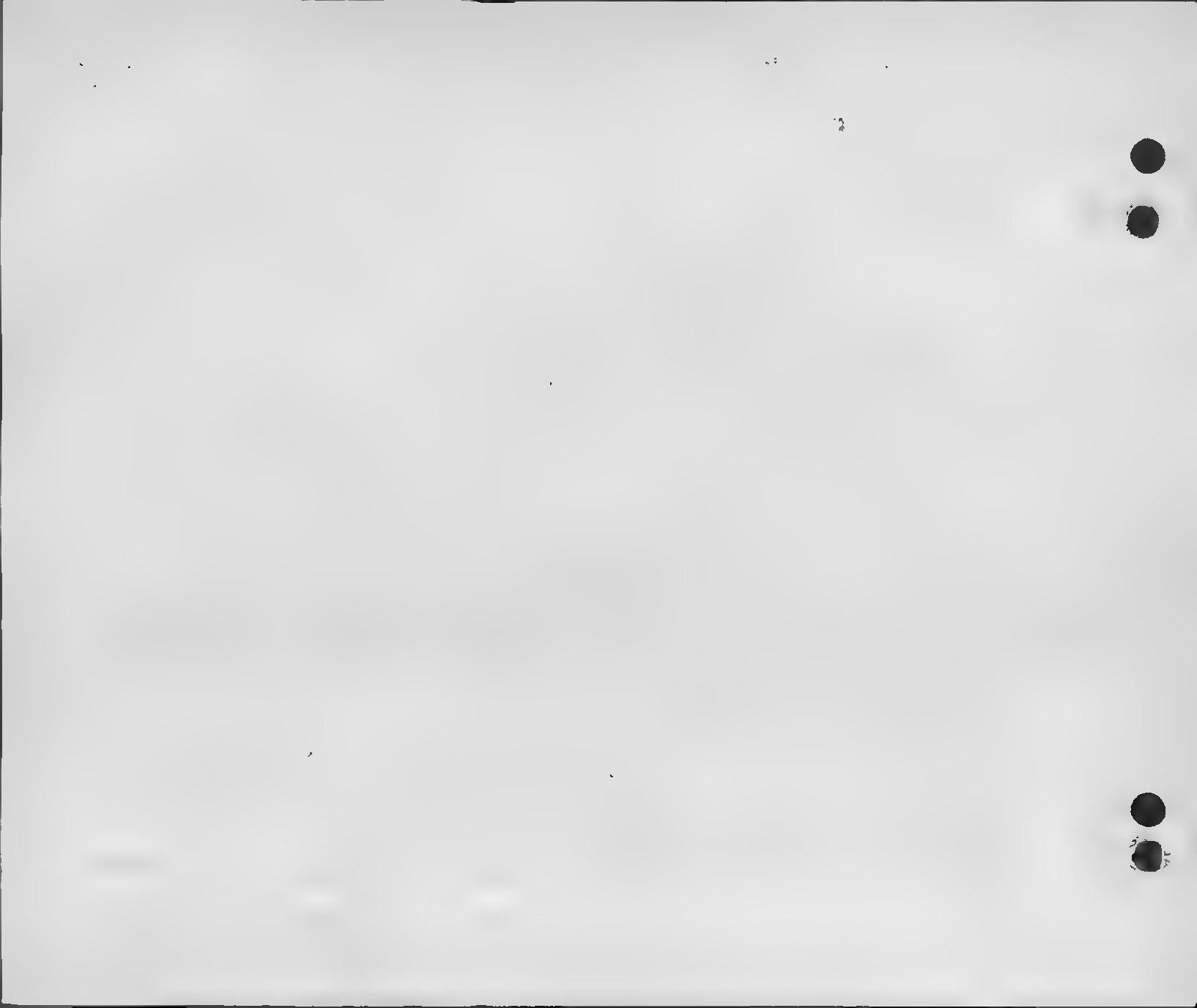
3. NAME OF DECEASED Walter L. Isaac
4. DATE OF DEATH May 24 1961
5. SEX male 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH July 29, 1866 9. AGE 94 yrs (last birthday) 10. MONTHS 24 11. DAYS 19 12. HOURS 01 13. MIN. 00

14. FATHER'S NAME William Williams 15. MOTHER'S MAIDEN NAME Nellie, unknown
16. SOCIAL SECURITY NO. Un. now. 17. INFORMANT Records: of the CR 2 18. ADDRESS U. S. A.

19. CAUSE OF DEATH (Enter only one cause; if more than one, list in order of importance)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute cardiac failure
DUE TO Generalized atherosclerosis
DUE TO chronic vascular disease
DUE TO accident fracture femur
PART II. ANTECEDENT DISEASE (b) 61 with an ant. rt. h. at r. fr. ct. of the r. femur; exact cause unknown
20. DESCRIBE HOW INJURY OCCURRED, IF ANY (c) at work
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Death resulted from ☐ Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

22. ACTUAL SIGNATURE George M. Adair, M.D. 23. EXAMINER'S NAME George M. Adair, M.D.
24. CHIEF MEDICAL EXAMINER 1010 Leake
25. AS STANT MEDICAL EXAMINER 1010 Leake
26. DEPUTY MEDICAL EXAMINER 1010 Leake

27. BURIAL, CREMATION, REMOVAL, SPECIFY Burial 28. DATE THEREOF May 27, 1961 29. NAME OF CEMETERY OR CREMATORY St. Stephens Cem. 30. LOCATION (City, town, or county) Catonsville 2nd, Md.
31. RECORD BY REGISTRAR May 26 '61 32. REGISTRAR'S SIGNATURE Arthur L. Hanna



Reg. Dist. No. 15251

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 20 yrs		2. USUAL RESIDENCE (Where deceased lived - If institution, Residec before admission) a. STATE Maryland		b. COUNTY Essex	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 502 Orings Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 502 Orings Ave.		3. NAME OF DECEASED (Type or print) First Benjamin Middle Werschel Last Jackson		4. DATE OF DEATH Month May Day 17 Year 1961	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 7, 1904		9. AGE (In years last birthday) 57 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) umber		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.		13. FATHER'S NAME James W. Jackson	
14. MOTHER'S MAIDEN NAME Jane S. Algire		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 220-22-9920		17. INFORMANT Mrs. Frances W. Jackson, Reisterstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of right lung X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of larynx DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 months 9 months		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that I attended the deceased from October 14, 1960 to May 15, 1961 that I last saw the deceased alive on May 15, 1961 , and that death occurred at 8:45 AM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) MD 11904 Reisterstown, Md. DATE SIGNED May 15, 1961	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 17, 1961		22c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens		22d. LOCATION (City, town or county) (State) Finksburg, Md.		23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.	
24a. REC'D BY REGISTRAR DATE MAY 16 '61		24b. REGISTRAR'S SIGNATURE Clarence E. Eline							

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The physician may be located at the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05252

1 PLACE OF DEATH a COUNTY <u>Baltimore Co</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a STATE <u>Baltimore</u> b COUNTY <u>BAL</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4151 IRISTOWN MD</u>		c LENGTH OF STAY IN 1b <u>16 days</u>	
d NAME OF HOSPITAL (If not in hospital, give street address) <u>BENT NURSING HOME</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Mary JACKSON</u>		4 DATE OF DEATH Month <u>5</u> Day <u>14</u> Year <u>1961</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>C</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1891</u>
9 AGE (In years last birthday) <u>70</u> yrs		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
<u>UNKNOWN</u>		<u>UNKNOWN</u>	
11 BIRTHPLACE (State or foreign country) <u>UNKNOWN</u>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <u>UNKNOWN</u>		14 MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO	
<u>UNKNOWN</u>		<u>UNKNOWN</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocarditis (chronic)</u> <u>113X</u> DUE TO (b) <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH (?) (?) (?)	
PART II OTHER SGNIFICANT CONDITIONS CONTR BUT NO TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-5-61</u> to <u>5-14-61</u> , that I last saw the deceased alive on <u>5-12-61</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James G. Saffell</u> M.D.		DATE SIGNED <u>5-16-61</u>	
PHYSICIAN NAME (Type)		ADDRESS (Street, city or town, state)	
<u>James G. Saffell</u>		<u>Reisterstown Md.</u>	
22a BURIAL, CREMATION, REMOVAL (Specify)	22b DATE THEREOF	22c NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county, State)
<u>1</u>	<u>6</u>	<u>1</u>	<u>1</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a REC'D BY REGISTRAR DATE <u>MAY 17 '61</u>	
ADDRESS		24b REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the attending physician and completely filled in by the funeral director, may be used for the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05253

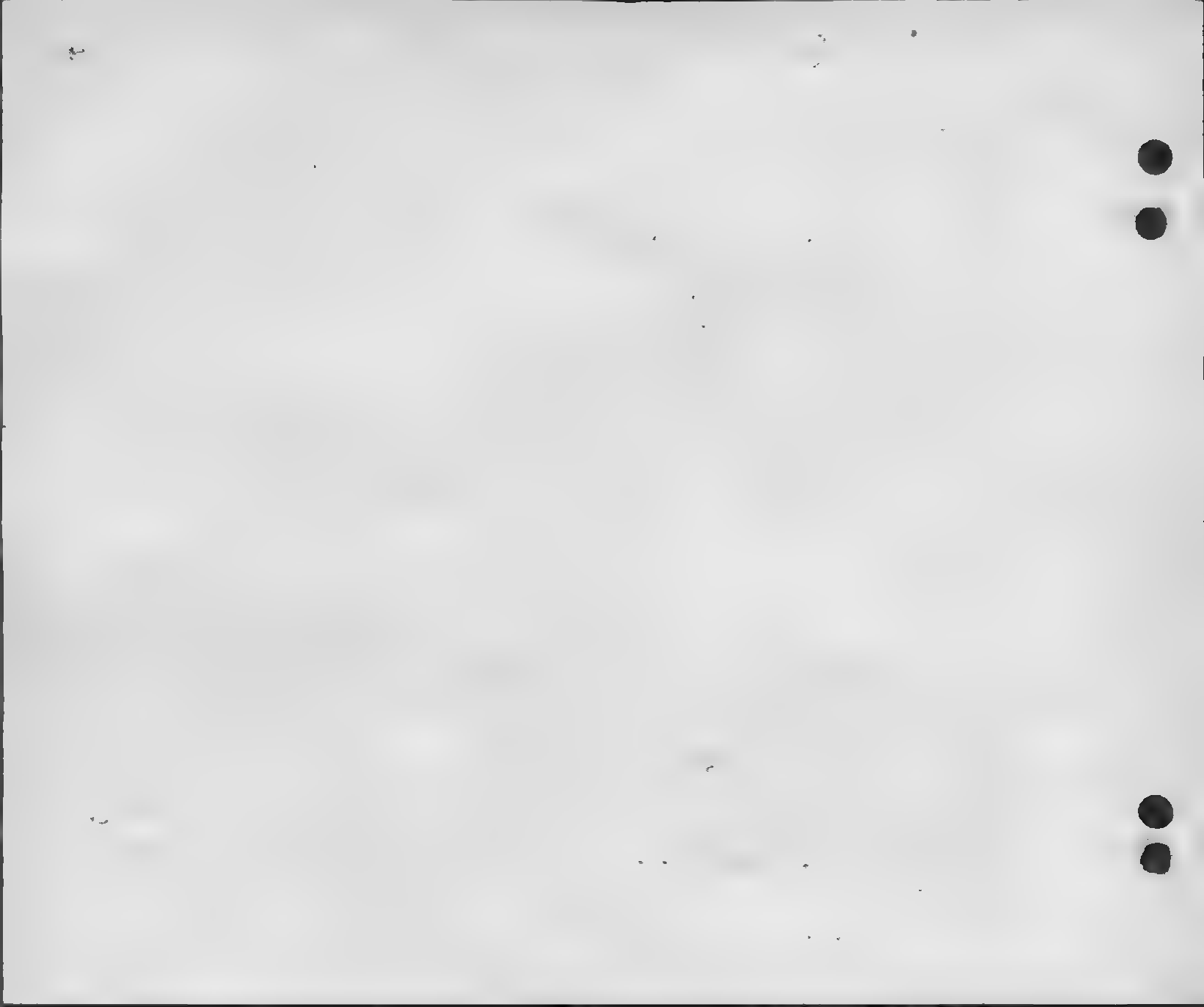
5261

1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside city limits, give rural and give nearest town) Catonsville
c. LENGTH OF STAY IN b. 11
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sidgeway Manor Nursing Home Formerly of 1822 Winchester St
e. STREET ADDRESS Baltimore
f. RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) William Ellis Jenkins
4. SEX Male
5. COLOR OR RACE W.
6. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
7. DATE OF BIRTH July 3, 1865
8. AGE (in years) IF UNDER 1 YEAR 95 Yrs IF UNDER 24 HRS. 5 Days 19 Hours 61 Min
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10. KIND OF BUSINESS OR INDUSTRY Conductor B. & O. R. R.
11. PLACE OF BIRTH Md.
12. CITIZENSHIP WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No
16. SOCIAL SECURITY NO. 1
17. INFORMATION Mrs. Ruth M. Fadden 204 S. London Ave

18. CAUSE OF DEATH [Enter only one cause per line, following Part I. Death was caused by IMMEDIATE CAUSE a) Coronary Occlusion
b) 8 hours
c) INTERVAL BETWEEN DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE, AND IN ANY NEAR 19. AUTOPSY PERFORMED? YES ☐ NO ☒
20. a. ACCIDENT WAS UNDER IN OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Give nature of injury in Part I or Part II of form 75)
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19 61 20d. INJURY CURRENT? While at work ☐ Not While at work ☒ PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
21. I certify that (I) (this hospital) attended the deceased from March 8, 1960 to May 5, 1961 that (I) (we) last saw the deceased alive on May 5, 1961, and that death occurred at 1:30 p.m. from the causes and on the date stated above
22a. SIGNATURE John F. Schaefer 22b. DATE SIGNED May 6, 1961
22c. PHYSICIAN'S NAME (Type) John F. Schaefer M.D. 22d. ADDRESS 401 Random Road #29
23a. BURIAL CREMATION REMOVAL (Specify) Burial 23b. DATE THEREOF 5/8/61 23c. NAME OF CEMETERY OR CREMATORY Meadowridge 23d. LOCATION (city, town or county) Hearsey A.A.C. Md
24. FUNERAL DIRECTOR'S SIGNATURE W. H. 4101 Edmondson Ave 25a. REC'D BY REG STRAR MAY 8 '61 25b. REGISTRAR'S SIGNATURE John F. Schaefer

TO HO... ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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75M 9:59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5262
Certificate of Death

05254

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived) If institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>506 Sudbrook Rd</u>		d STREET ADDRESS <u>506 Sudbrook Rd</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>George Alexander Johns</u>		4 DATE OF DEATH Month Day Year <u>May 29 1961</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov 5, 1880</u>
9 AGE (In years) <u>80</u> <u>181</u> yrs		10 UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Physician</u>	
11 BIRTHPLACE (State or foreign country) <u>Ontario, Canada</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>George Johns</u>		14 MOTHER'S MAIDEN NAME <u>Mary McAlpine</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>493361430</u>	
17 INFORMANT <u>Dr Viola B. Johns</u>		Address <u>506 Sudbrook Rd Pikesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 1521 DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (c) <u>Indefinite</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>none</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Jan 18 1960</u> to <u>May 29 1961</u> , that (I) (we) last saw the deceased alive on <u>May 20 1961</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above			
22a SIGNATURE <u>George C. Modairy M.D.</u> M.D.		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) <u>George C. Modairy M.D.</u>		22d ADDRESS <u>230 Main St., Reisterstown, Md.</u>	
23a BURIAL CREMATION REMOVAL (Specify) <u>burial</u>		23b DATE THEREOF <u>June 1, 1961</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Truid Ridge Cemetery</u>		23d LOCATION (City, town or county) (State) <u>Pikesville, Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Eline & Sons</u>		ADDRESS <u>Reisterstown, Md.</u>	
25a REC'D BY REGISTRAR <u>1</u>		25b REGISTRAR'S SIGNATURE <u>William P. Jones</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5263

05255

PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard
c. LENGTH OF STAY IN b 23 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital
2. USUAL RESIDENCE (Where deceased lived last 12 months)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1839 W. Mulberry Street (17)
d. STREET ADDRESS
3. NAME OF DECEASED
First Middle Last
JOHN E. JOHNSON
4. DATE OF DEATH
Month Day Year
May 23 19 61
5. SEX Male
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH
Month Day Year
October 8, 1892 68 yrs
9. AGE (in years last birthday) IF UNDER 1 YEAR, IN ORDER 4 HRS. Months Days Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Scale Man
11. KIND OF BUSINESS OR INDUSTRY Motor Transport Co. Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Albert Johnson
14. MOTHER'S MAIDEN NAME Belle Harper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch and date of entry) Yes WW I
16. SOCIAL SECURITY NO. 215-05-8186
17. Address Baltimore 10, Md.
18. CAUSE OF DEATH (Enter only one cause - brief, but not less than 10 words)
PULMONARY EDEMA
ARTERIOSCLEROTIC HEART DISEASE
19. Was AUTOPSY PERFORMED? YES ☒ NO ☐

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE
PULMONARY EDEMA
ARTERIOSCLEROTIC HEART DISEASE
DUE TO
DUE TO
DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I)
1. Nephrosclerosis. 2. Encephalomalacia. 3. Diabetes Mellitus-Clinical
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20c. INJURY OCCURRED While at work ☐ Not While at work ☐
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20e. City or town
20f. (County)
20g. (State)

21. I certify that (this hospital) attended the deceased from April 29, 1961, to May 23, 1961, that (we) last saw the deceased alive on May 23, 1961, and that death occurred at 11:30 P.M. from the causes and on the date stated above.
22a. SIGNATURE Thomas F. Crahan M.D.
22b. DATE SIGNED 5/24/61
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.
22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION
22e. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF May 24, 1961
23c. NAME OF CEMETERY OR CREMATORY Baltimore National
23d. LOCATION (City, town or county) Baltimore
23e. (State) 20, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Katie R. Williams
25a. RECORD BY REGISTRAR MAY 29 1961
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus

25c. ADDRESS 322 N. Schroeder St. Balto. 23, Md.



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MEDICAL CERTIFICATION



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5265
5265
05257
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN, if out of corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b) 11 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, institution, Rest Home, etc.) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN, if out of corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 20 North Gorman Avenue	
3. NAME OF DECEASED (Type or print) JOHN B. JONES		4. DATE OF DEATH Month May Day 16 Year 1961	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH March 8, 1887	
9. AGE (in years) 74 yrs		10. AGE (in years) last birthday Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handy Man		10b. KIND OF BUSINESS OR INDUSTRY Chemical Company	
11. PLACE OF BIRTH Salvia, Virginia		12. CITIZENSHIP U. S. A.	
13. FATHER'S NAME George Jones		14. MOTHER'S MAIDEN NAME Josephine Washington	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes, give war, grade, service) Yes WW I		16. SOCIAL SECURITY NO 212-09-3024	
17. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE CEREBROVASCULAR ACCIDENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause as ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE CARCINOMA OF PROSTATE WITH METASTASIS TO THE BONES PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		18. INTERVAL BETWEEN ONSET AND DEATH 6 DAYS	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20a. TIME OF INJURY Hour 19 a.m. p.m.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 5 19 61 , to May 16 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 16 19 61 , and that death occurred at 7:45 A.M. from the causes and on the date stated above.		22a. SIGNATURE Thomas F. Crahan M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22b. DATE SIGNED 5/16/61		22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D. VAH, BALTO. 18, MARYLAND, FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles G. Cooper		25a. REC'D BY REGISTRAR MAY 18 '61	
25b. REGISTRAR'S SIGNATURE James L. Thomas			



TO HO **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 48 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5266

258

1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN Fort Howard
c. LENGTH OF STAY IN 1b 11 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital
e. STREET ADDRESS Rt. 2

2. USUAL RESIDENCE (Where deceased lived first full year)
a. STATE Maryland
b. COUNTY Anne Arundel
c. CITY OR TOWN Traceys Landing

3. NAME OF DECEASED
First THOMAS Middle - - - Last JONES

4. DATE OF DEATH
Month May Day 19 Year 1961

5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH August 2, 1894

9. AGE, in years (last birthday) 66 yrs. IF UNDER 1 YEAR: Months 6 Days 1 Hours 0 M 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman
10b. KIND OF BUSINESS OR INDUSTRY Sea Food
11. BIRTHPLACE Calvert County, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Jones 14. MOTHER'S MAIDEN NAME Mary Reed

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. 217-07-3380 17. INFORMANT Clinical Records 18. ADDRESS VA Hospital
3900 Loch Raven Blvd. Balto 18, Md. Ft Howard Div.

18. CAUSE OF DEATH (In or only one cause per line for a, b, c, d.)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
DUE TO (b) HYPERTROPHY AND DILATATION OF THE HEART
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Unknown
DUE TO (c) Unknown

PART II. OTHER (LONG AND SHORT) CONTRIBUTING CAUSES (DEATH BUT NOT CAUSED BY THE TERMINAL DISEASE, LONG OR SHORT) YES ☒ NO ☐
Bronchopneumonia-one week. Adenoma, Unspecified, of the Pituitary-unk

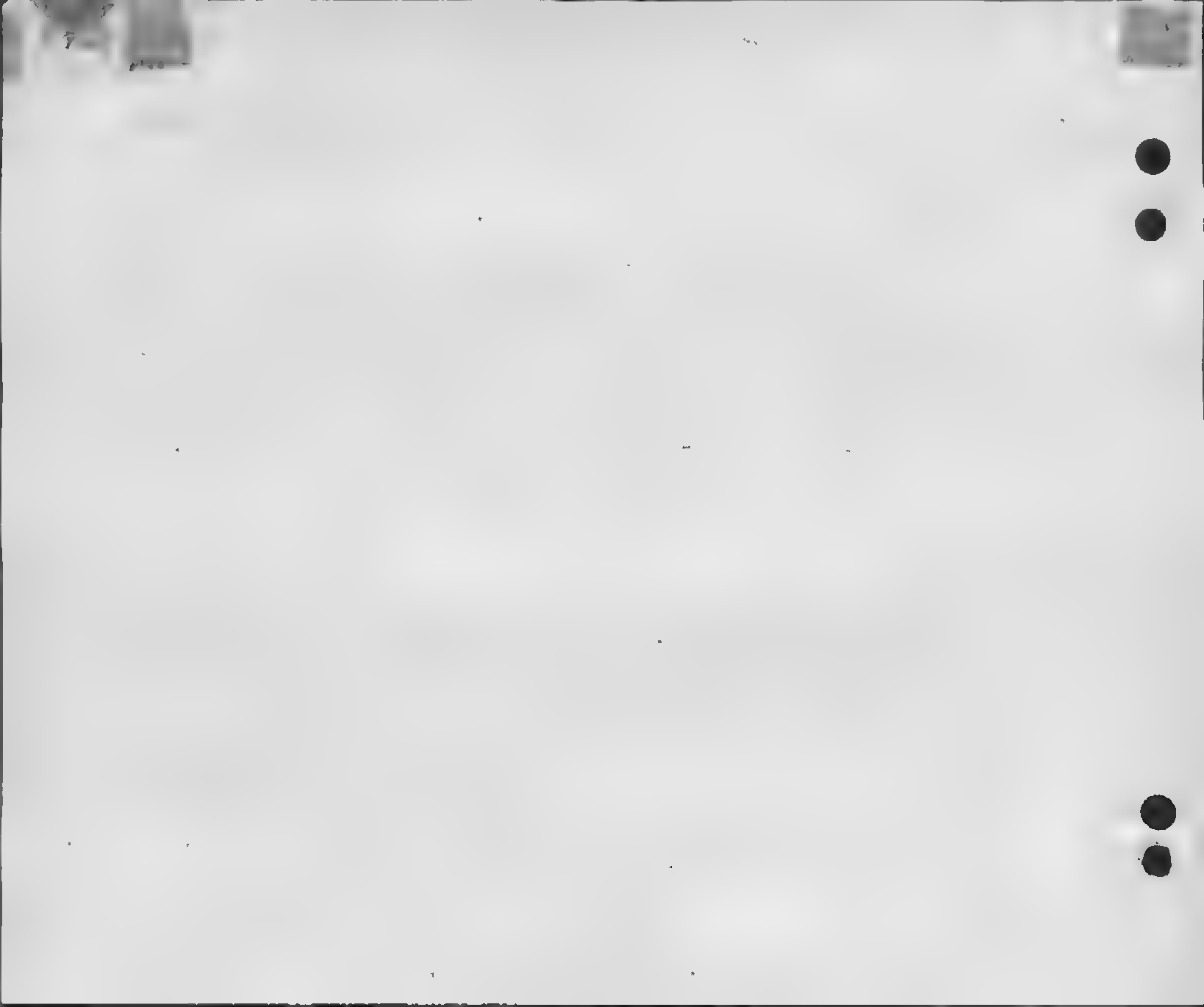
20a. AGE AT TIME OF INJURY OR CONTRIBUTING CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER
20b. DESCRIBE HOW INJURY OCCURRED
20c. TIME OF INJURY Month Day Year Hour e.m. p.m. 19 May 8 1961
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (factory, street, office bldg., etc.)

21. I certify that ☒ (this hospital) attended the deceased from May 8 1961 to May 19 1961 that ☒ (we) last saw the deceased alive on May 19 1961 and that death occurred at P M. from the causes and on the date stated above

22. SIGNATURE Charles Allen M.D. ATTENDING PHYSICIAN ☐ MED. DIRECTOR ☐ STAFF PHYSICIAN ☒ DATE 5/20/61
22a. PHYSICIAN'S NAME (Type) CHARLES ALLEN, M.D.
22b. ADDRESS 3900 Loch Raven Blvd. Balto 18, Md. FORT HOWARD DIVISION.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5-24-61 23c. NAME OF CEMETERY OR REMATORY Union Chapel Church Cemetery 23d. LOCATION (city or town or county) Tracey's Landing, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE Pinkney Sewell ADDRESS Funeral Home, Prince Frederick, Md. DATE MAY 29 '61 25. REGISTRAR SIGNATURE Charles E. Hester



VS AIS (4)
15M 9/SB



YR AIS (4)
ISM 9/59

CERTIFICATE OF DEATH

before admittance
more

1 PLACE OF DEATH a COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a STATE Md. b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1109 Oakland Terrace Rd.		d STREET ADDRESS 1109 Oakland Terrace Rd.	
3 NAME OF DECEASED (Type or print) Earl Linwood Kelly		4 DATE OF DEATH Month May Day 11 Year 1961	
5 SEX male		6 COLOR OR RACE white	
7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH July 1, 1903	
9 AGE (In years last birthday) 57 yrs		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months 57 Days 57 Hours 57 Min 57	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) molding supt.		10b KIND OF BUSINESS OR INDUSTRY Coppers Co.	
11 BIRTHPLACE (State or foreign country) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME James C. Kelly		14 MOTHER'S MAIDEN NAME Laura A. Stuart	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16 SOCIAL SECURITY NO. Helen M. Kelly 1109 Oakland Terrace Rd.	
17 INFORMANT Helen M. Kelly		18 ADDRESS 1109 Oakland Terrace Rd.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 120.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <input type="checkbox"/>	
20c TIME OF INJURY Month May Day 11 Year 1961 Hour 11 a. m. 11 p. m. 11		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY Home farm factory, street, office bldg., etc. Francis Avenue		20f (City or town) (County) (State) Baltimore, Maryland	
21 I certify that () (this hospital) attended the deceased from 5/1/56 to 5/11/61 that (I) (we) last saw the deceased alive on 5/1/61 and that death occurred at 11:00 AM from the causes and on the date stated above		22a SIGNATURE John Healy, M. D.	
22b DATE SIGNED 5/11/61		22c ADDRESS Francis Avenue	
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF 5/15/61	
23c NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d LOCATION (City town or county) (State) Baltimore, Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		24b ADDRESS 4107 Wilkens Ave.	
25a REC'D BY REGISTRAR May 11 1961		25b REGISTRAR'S SIGNATURE Francis Avenue	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

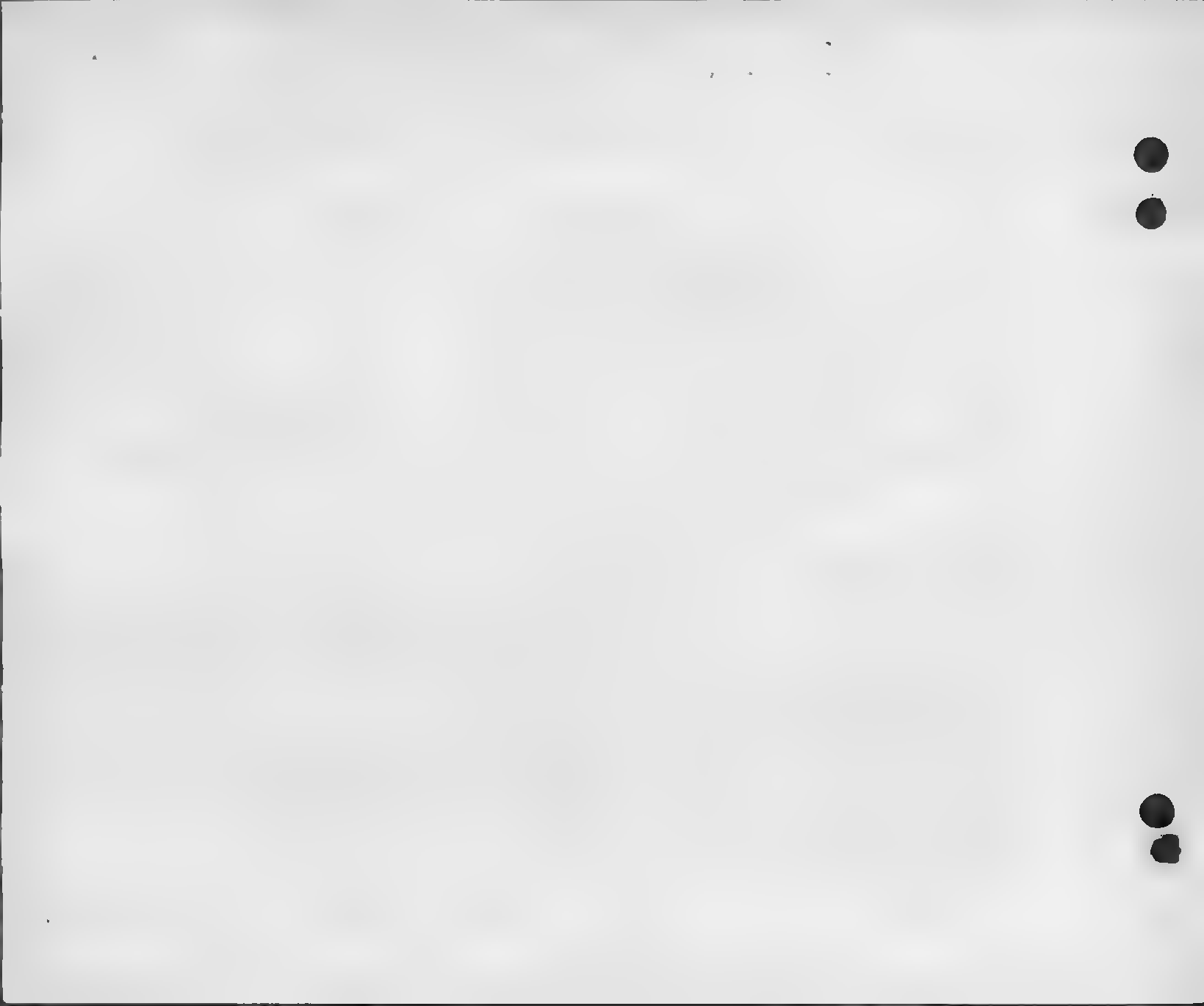
CERTIFICATE OF DEATH

Reg. Dist. No.

15334

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		e. STREET ADDRESS Glenarm, Maryland	
3. NAME OF DECEASED (Type or print) First Sister Mary Almira Kelly Middle Kelly Last Kelly		4. DATE OF DEATH Month 5 Day 15 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-27-1995
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months 6 Days 15 Hours 15 Min 15	11. IF UNDER 24 HRS Months 6 Days 15 Hours 15 Min 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Religious.	
11. BIRTHPLACE (State or foreign country) Concord, Mass.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Kelly, Maurice		14. MOTHER'S MAIDEN NAME Nolin, Elizabeth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO Sr.M. Henrica	
17. INFORMANT Villa Maria, Glenarm, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Carcinoma X DUE TO Carcinoma of the breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) 2 years DUE TO (c) 1 year		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February, 1961 , to May, 1961 , that I last saw the deceased alive on May 9, 1961 , and that death occurred at 8 p. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 7501 York Road, Towson 4, Md. DATE SIGNED			
ACTUAL SIGNATURE Charles F. O'Donnell			
PHYSICIAN'S NAME (Type) Charles F. O'Donnell			
22a. BURIAL CREMATION, REMOVAL (Specify) 5/10/61		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Villa Maria Cemetery		22d. LOCATION (City, town, or county) (State) Towson 4, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles F. O'Donnell		24a. REC'D BY REGISTRAR DATE May 10 1961	
24b. REGISTRAR'S SIGNATURE May 10, 1961			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the attending physician and completely filled in the funeral director's page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The attending physician, the hospital or attending physician, may file this certificate with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

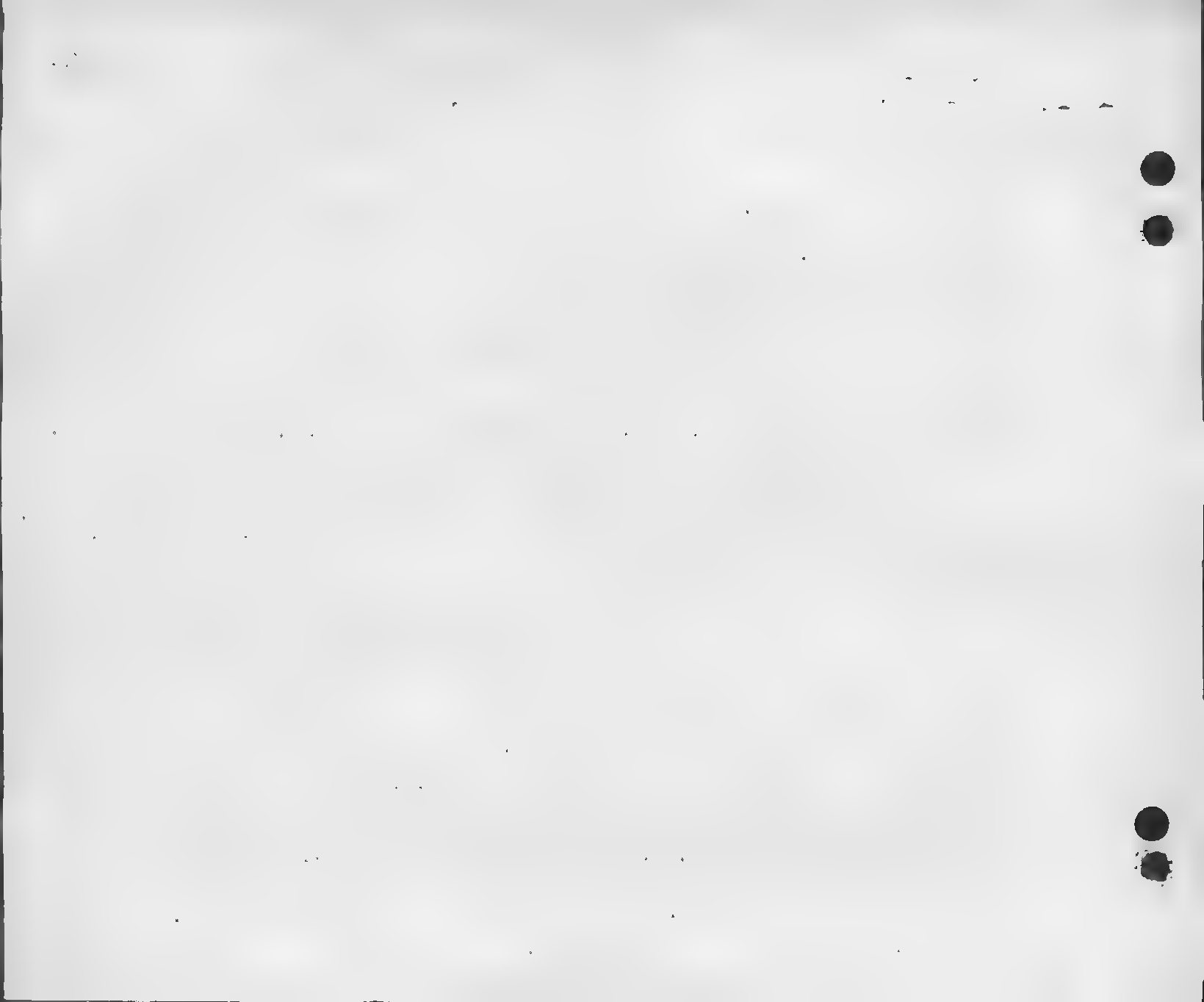
VR A15 (4)
15M 9/59

5269

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 7, MARYLAND
CERTIFICATE OF DEATH

45261

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Arbutus		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Boyce	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4200 Fordham Rd.		d. STREET ADDRESS	
1 NAME OF DECEASED (Type or print) Alma O. Kibler		4. DATE OF DEATH Month May Day 24 Year 19 61	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 8, 1890
9 AGE (in years last birthday) 71 yrs		F UNDER 1 YEAR Months Days Hours Min. F UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11 BIRTHPLACE (State or foreign country) Lurray, Virginia		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Thomas Barham F		14 MOTHER'S MAIDEN NAME Judge	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, If yes, give war or dates of service)		16 SOCIAL SECURITY NO 230-52-8034	
17 INFORMANT A Margaret Prunkel		Address 4200 Fordham Rd.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a), DUE TO Carcinoma of Uterus and Ovaries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Metastasis to Liver and Stomach (c) Anasarca		INTERVAL BETWEEN ONSET AND DEATH About 1 1/2 yrs. About 1 yr. About 4 months	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (the hospital) attended the deceased from Jan. 24, 19 61 to May 24, 19 61 , that (I) (we) last saw the deceased alive on May 10, 19 61 and that death occurred at 10 a.m. from the causes and on the date stated above.			
22a SIGNATURE Ernest G. Marr		22b DATE May 25, 1961	
22c PHYSICIAN'S NAME (Type) ERNEST G. MARR, M. D.		22d ADDRESS 616 Cathedral St., Baltimore, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 5/27/61	
23c NAME OF CEMETERY OR CREMATORY Mt. Hebron		23d LOCATION (City, town or county) (State) Winchester, Va.	
24 FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a REC'D BY REGISTRAR May 29 '61	
ADDRESS 4107 Wilkens Ave.		25b REGISTRAR'S SIGNATURE Charles L. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

16 262

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural</u>		d. STREET ADDRESS <u>Glenarm, Maryland</u>	
3 NAME OF DECEASED (Type or print) <u>Sister Mary Adeline Ill. ffer</u>		4 DATE OF DEATH Month <u>5</u> Day <u>3</u> Year <u>19 61</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 15, 1870</u>
9. AGE (In years last birthday) <u>91</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Religious</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>John Kieffer</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Wiest</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Sr. M. Henrica</u>		Address <u>Villa Maria-Glenarm, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>			
DUE TO <u>Generalized Arteriosclerosis</u>			
DUE TO <u>10 years</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day, Year Hour a m p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan.</u> 19 <u>52</u> to <u>April</u> 19 <u>61</u> that I last saw the deceased alive on <u>April 25</u> 19 <u>61</u> and that death occurred at <u>11 p.m.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		ADDRESS (Street, city or town, state) <u>7501 York Road</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES F. O'DONNELL</u>		DATE SIGNED <u>5/8/61</u>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5-10-61</u>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Seiler</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5271

05263

1 PLACE OF DEATH

a. COUNTY

Baltimore

b. CITY OR TOWN, if outside corporate limits write RURAL and give nearest town

Fort Howard

MARYLAND

c. LENGTH OF STAY IN b

5 Days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Veterans Administration Hospital

3. NAME OF DECEASED
(Type or print)

EDWARD

First

Middle

P.

2. USUAL RESIDENCE (Where deceased lived if not in institution)

a. STATE

Maryland

b. COUNTY

Queen Annes

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Centreville

d. STREET ADDRESS

Route 2

4. DATE OF DEATH

Month

May

29

1961

9. AGE (in years if under 1 year, under 1 hrs., last birthday) Months Days Hours Min

43 yrs

5. SEX

Male

6. COLOR OR RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

September 7, 1917

10a. USUAL OCCUPATION Give kind of work done during most of work life, even if retired

Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY

Trucking

11. PLACE OF BIRTH

Centreville, Maryland

12. CITIZEN OF WHAT COUNTRY?

U? S. A.

13. FATHER'S NAME

Lloyd Kilson

14. MOTHER'S MARRIAGE

Augusta (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes, give year or dates of service)

Yes

WW II

16. SOCIAL SECURITY NO.

216-16-7195

17. INFORMANT

Clinical Records, VAH, Baltimore 18, Maryland

FORT HOWARD DIVISION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

BRONCHOPNEUMONIA

INTERVAL BETWEEN ONSET AND DEATH

5 DAYS

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

PORTAL CIRRHOSIS OF LIVER

UNKNOWN

CHRONIC GASTRITIS, ESOPHAGITIS

UNKNOWN

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a. 19. WAS AUTOPSY PERFORMED?

Operation: Status Post Subtotal gastrectomy for bleeding peptic ulcer.

YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II or item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (X) (this hospital) attended the deceased from May 24, 1961, to May 29, 1961, that (X) (we) last saw the deceased alive on May 29, 1961, and that death occurred at 7:30 A.M. from the causes and on the date stated above

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

ROWLAND H. ROBERTSON, JR.

M. D.

VAH, BALTO. 18, MD. FT. HOWARD DIVISION

23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify)

Burial

JUNE 3

23c. NAME OF CEMETERY OR CREMATORY

BURRISVILLE CEM.

23d. LOCATION (City, town or county)

Burrsville, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REG. STRAR

25b. REGISTRAR'S SIGNATURE

Edgar Lane

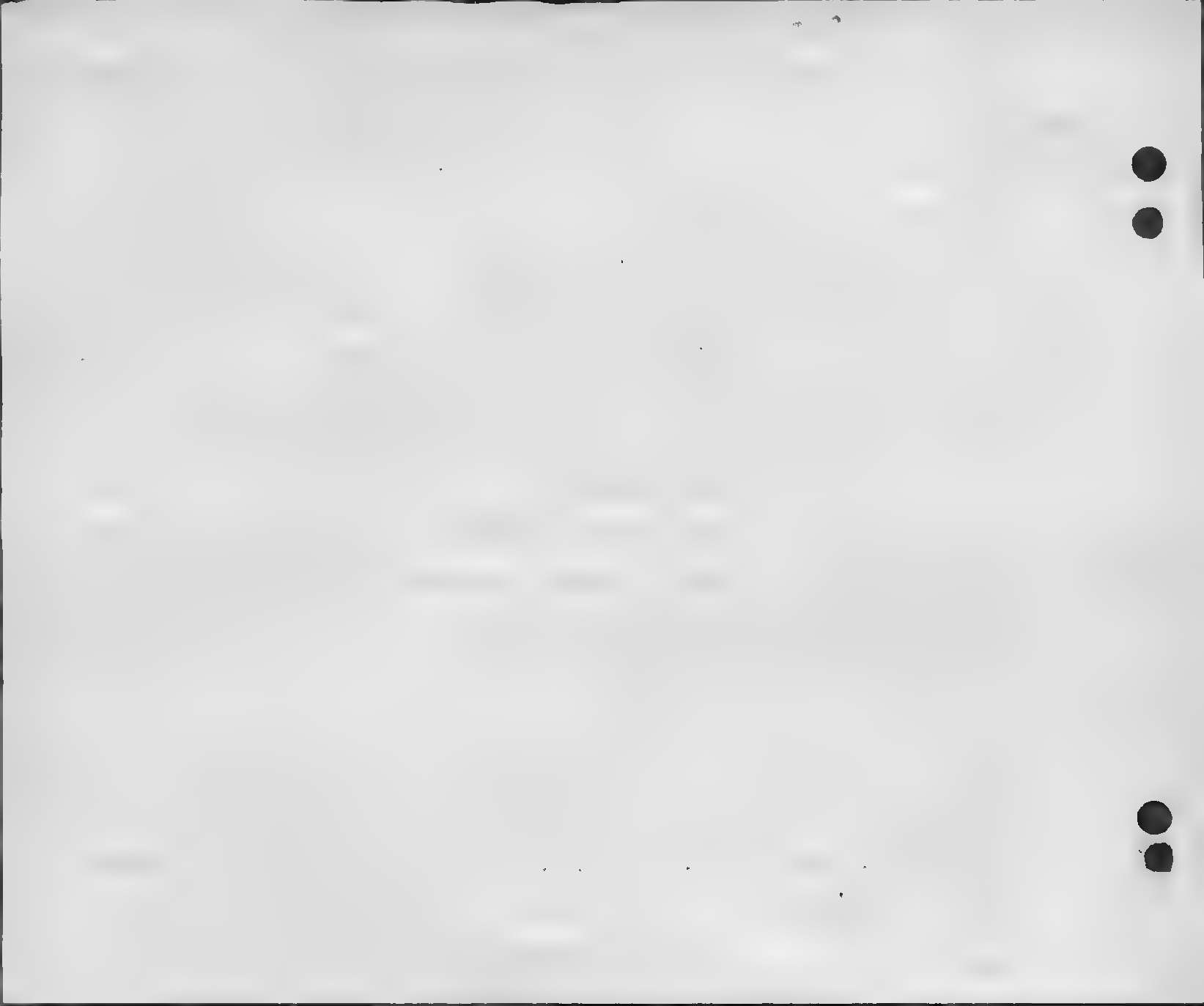
Church Hill, Maryland

DATE JUN 5 '61

Richard S. Kline

TO BE FILLED BY ATTENDING PHYSICIAN - The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5972

05264

1. PLACE OF DEATH
a. COUNTY **Baltimore** **MARYLAND**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Catonsville 28**
c. LENGTH OF STAY IN b. **Baltimore 11**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Ridgeway Manor**
5743 Edmondson Avenue
4201 Elsa Terrace

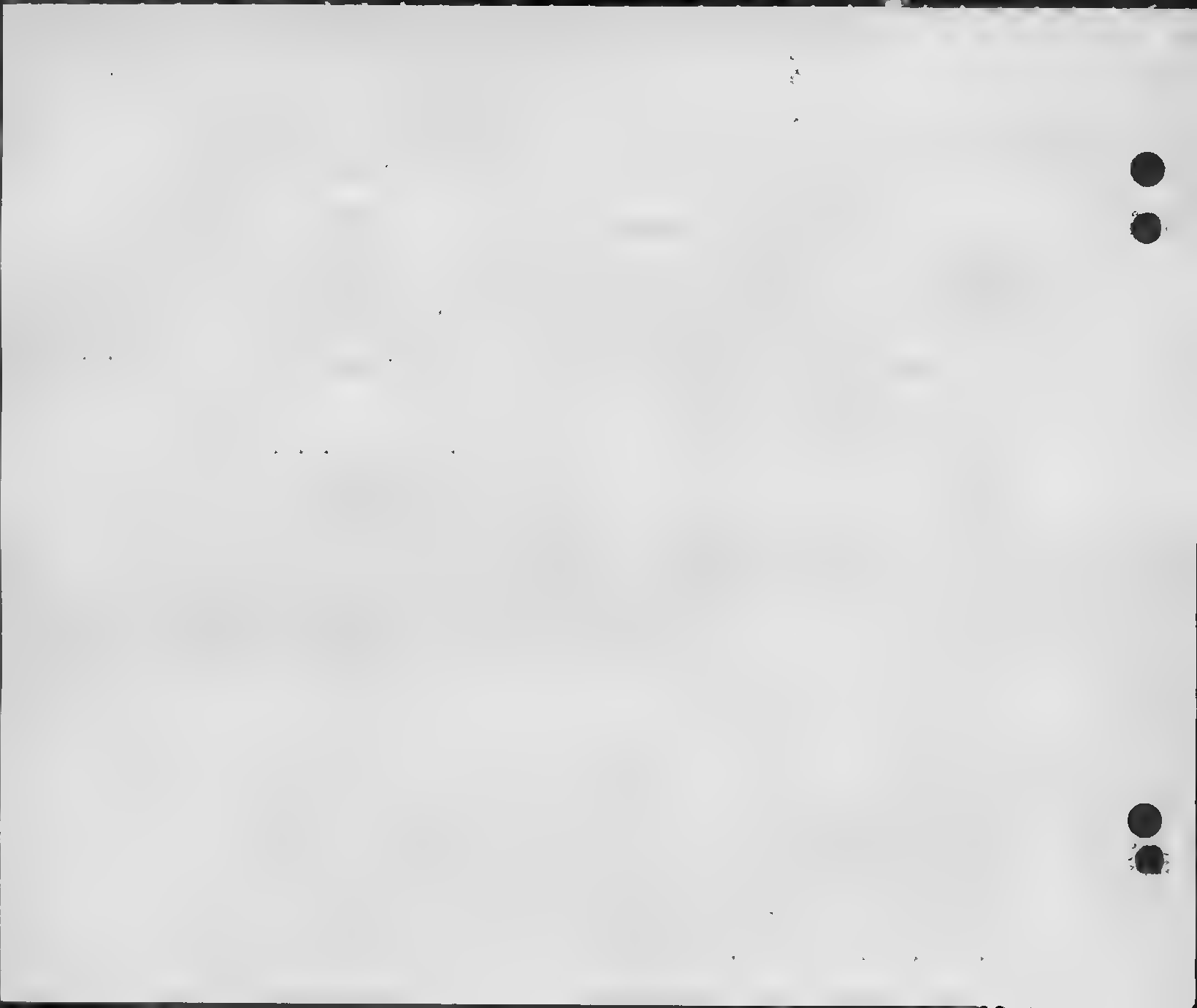
2. USUAL RESIDENCE (Where deceased lived, if not in residence, b. 5. RESIDENCE ON A FARM? YES ☒ NO ☐
a. STATE **Maryland** b. COUNTY **Baltimore**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Baltimore 11**
d. STREET ADDRESS **4201 Elsa Terrace**
e. DATE OF DEATH **May 21 1961**
f. AGE (in years last birthday) **77** g. UNDER 1 YEAR **1** h. UNDER 2 HRS. **1**
i. MONTHS **1** j. DAYS **1** k. HRS. **1** l. MIN. **1**
m. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife**
n. KIND OF BUSINESS OR INDUSTRY **10b** o. BIRTHPLACE **Virginia** p. CITIZEN OF WHAT COUNTRY? **U.S.A.**
q. FATHER'S NAME **unknown** r. MOTHER'S MAIDEN NAME **unknown**
s. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **15** t. SOCIAL SECURITY NO. **16** u. INFORMANT **George W. Knight, R.F.D. 2, Box 296**
v. ADDRESS **17**

18. CAUSE OF DEATH (Enter only one cause, but list all contributing conditions contributing to death but not related to the terminal disease condition given in Part 1)
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a), DUE TO **Coronary Artery Disease**
Conditions (any which gave rise to immediate cause (a), stating the underlying cause last. (b) **Cardiovascular Renal Disease**
(c) **Chronic Urtemia**
PART 1: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1
Coronary Thrombosis at left side Hemiplegia 8 years
20a. A. DID NOT WA UNDERLYNG OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) **20b. DESCRIBE HOW INJURY OCCURRED** (Enter nature of injury in Part 1 or Part 1 of item 18)
20c. TIME OF INJURY Month, Day, Year **19** 20d. INJURY OCCURRED **4/4** 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **1960** 20f. City or town **5/21** County **1961** (State)
20g. Hour a.m. **4:30** p.m. **4:30** 20h. While at work ☐ Not While at work ☐
21. I certify that () (this hospital) attended the deceased from **4/4** **1960** to **5/21** **1961**, that (I) (we) last saw the deceased alive on **5/20** **1961**, and that death occurred at **4:30** from the causes and on the date stated above.
22a. SIGNATURE **Edna W. Johnson** 22b. DATE SIGNED **5/24/61**
22c. PHYSICIAN'S NAME (Type) **3432** 22d. ADDRESS **1217 St. Paul Street**
23a. BURIAL, CREMATION REMOVAL (Specify) **BURIAL** 23b. DATE THEREOF **5-24-61** 23c. NAME OF CEMETERY OR CREMATORY **Moreland Memorial** 23d. LOCATION (City, town or county) **Taylor Ave. & Daltford Rd.**
24. FUNERAL DIRECTOR'S SIGNATURE **Wm. Cook, Inc., 1217 St. Paul Street** 25a. REC'D BY REGISTRAR **DATE MAY 24 1961** 25b. REGISTRAR'S SIGNATURE **William F. Thomas**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 15265

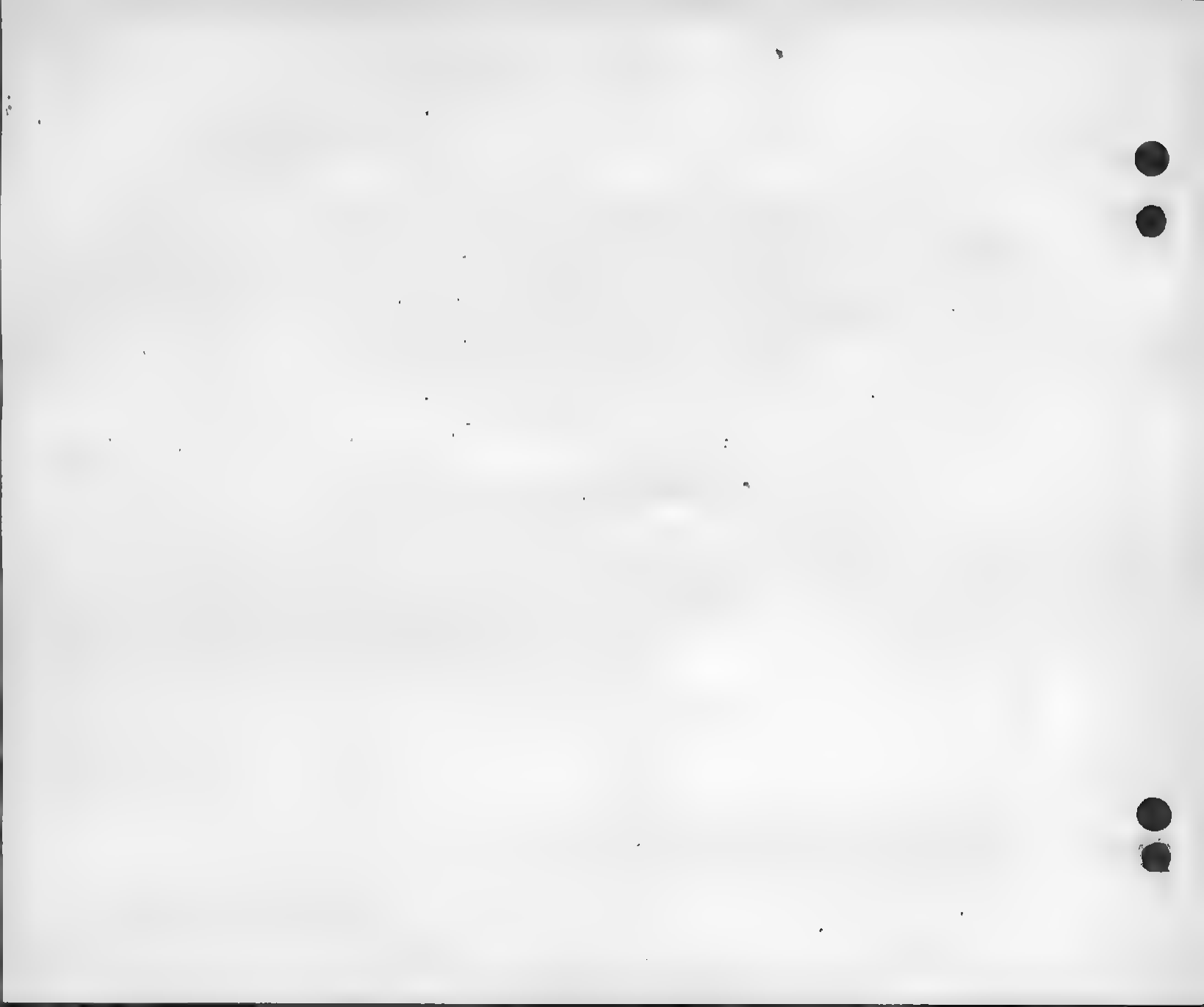
1 PLACE OF DEATH a COUNTY <u>BALTO -</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c LENGTH OF STAY IN 1b <u>LIFE</u>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Longgreen Nurs Home</u>		e STREET ADDRESS <u>115 E. MELROSE AVE</u>	
3. NAME OF DECEASED (Type or print) <u>ROSAM</u> First Middle <u>(GRADY)</u> Last <u>KOORS</u>		4. DATE OF DEATH Month <u>5</u> Day <u>6</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 13 - 1877</u> 9 AGE in years last b. day! <u>83</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11 BIRTHPLACE (State or foreign country) <u>BALTO Md</u>
13 FATHER'S NAME <u>John H. GRADY</u>		14 MOTHER'S MAIDEN NAME <u>LENA Richards</u> 321 DUNKIRK RD BALTO MD	
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO <u>NO</u>	
17. INFORMANT <u>Sister</u> Address <u>MRS. Charlotte STUMP</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Arteriosclerosis + Diabetes</u> DUE TO (c) <u>Art. Sclerosis + Ch. B. disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>✓</u> p. m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1945</u> , 19 <u>56</u> to <u>5-6-61</u> , that I last saw the deceased alive on <u>5-6-61</u> , and that death occurred at <u>9 P</u> M. from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Charles Victor Richards</u> M.D.		ADDRESS (Street, city or town, state) <u>321 DUNKIRK RD BALTO MD</u> DATE SIGNED <u>5-6-61</u>	
PHYSICIAN'S NAME (Type) <u>Charles Victor Richards</u>			
22a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-10-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	22d LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Lockner & Sons</u> ADDRESS <u>Baltimore, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 8 1961</u>	24b. REGISTRAR'S SIGNATURE



Reg Dist No 00265

M

✓S A15 (4)
15M 9/5B



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5275

U5267

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived 1 month or more before death) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN, if in a corporation, limit 100 characters; if not, write RURAL and give nearest town <u>Baltimore</u>		c. CITY OR TOWN, if outside of corporation, limit 100 characters; if not, write RURAL and give nearest town <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3123 Garden Ave.</u>		e. STREET ADDRESS <u>3123 Garden Ave.</u>	
3. NAME OF DECEASED (Type name in full) <u>Curigunda Catherine Lahner</u>		4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. AGE In () years <u>64</u> Months <u>1</u> Days <u>19</u> Hours <u>01</u> Min. <u>01</u>	
9. OCCUPATION (If deceased was engaged in a profession, trade, or occupation during most of working life, even if retired) <u>Housekeeper</u>		10. BUSINESS OR INDUSTRY <u>Church Rectory, Baltimore, Maryland</u>	
11. FATHER'S NAME <u>JOSEPH NEUBAUER</u>		12. MOTHER'S MAIDEN NAME <u>ANNIE M. (UNKNOWN)</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>		14. SOCIAL SECURITY NO. <u>3-24-1897</u>	
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) <u>—</u>		16. INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>—</u>		17. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
18a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED (If nature of injury in Part I or Part II or item 18)	
19a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		19b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20a. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.)		20b. CITY OR TOWN, County, State	
21. I certify that (I) (the hospital) attended the deceased from <u>Mar. 1, 1947</u> to <u>May 1, 1961</u> , that (I) (we) last saw the deceased alive on <u>May 1, 1961</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>L.B. STEVENS</u>		22b. ADDRESS <u>5425 Roman Ave, Baltimore, Md</u>	
22c. PHYSICIAN'S NAME (Type) <u>L.B. STEVENS</u>		22d. ADDRESS <u>5425 Roman Ave, Baltimore, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/5/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		23d. LOCATION (City, town or county) <u>BALTIMORE</u> (State) <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Kuck Inc.</u>		25a. REC'D BY REGISTRAR <u>Arthur L. Kuehn</u> 25b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>MAY 4 '61</u>		DATE <u>MAY 4 '61</u>	

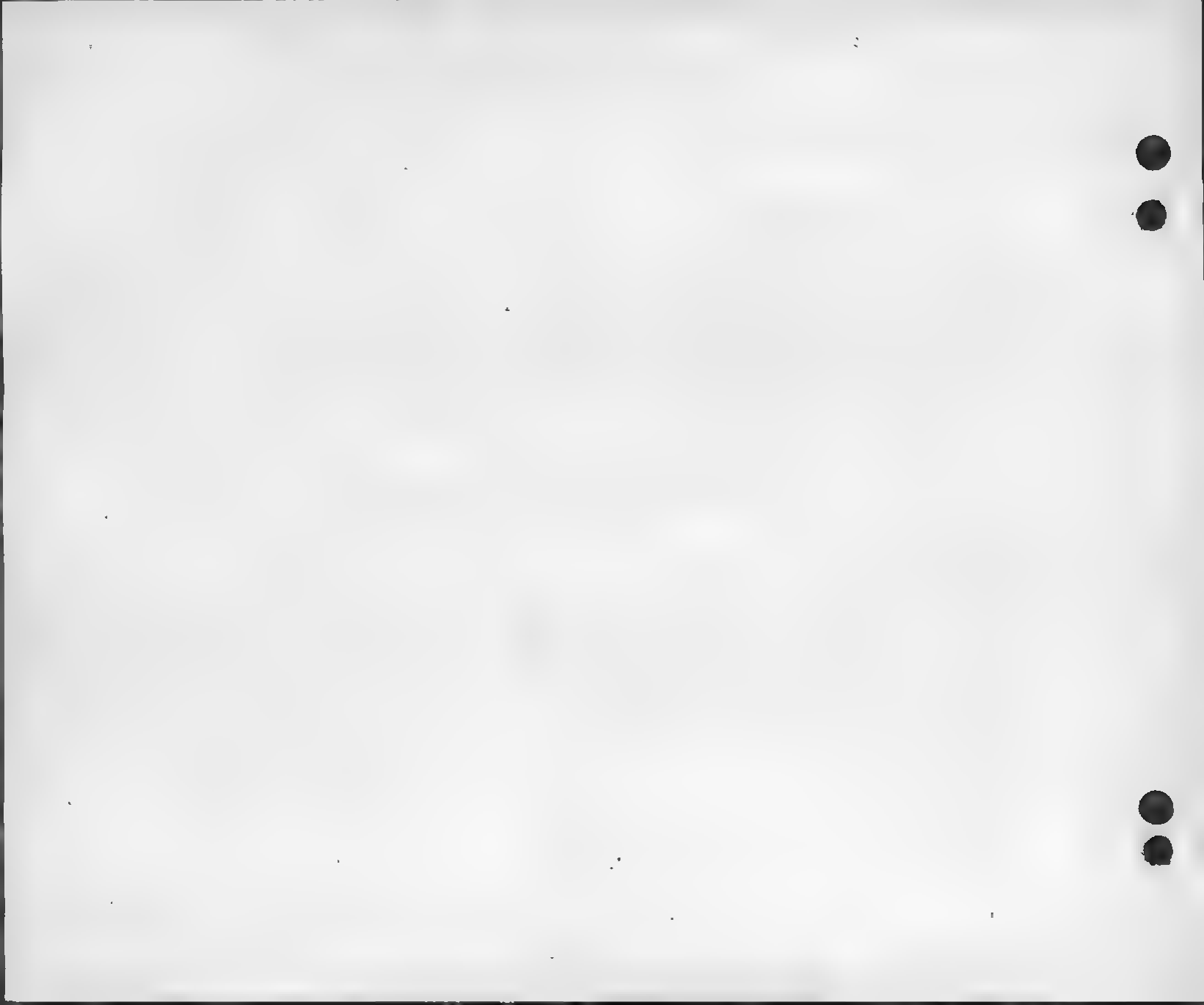


5276 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

Reg. Dist No

05268

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Woodlawn c. LENGTH OF STAY IN It d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2108 Northland Road		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn d. STREET ADDRESS 2108 Northland Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First JOHN Middle FOREST Last LANDIS		4. DATE OF DEATH Month May Day 11 Year 1961	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 17, 1881
9 AGE (in years last birthday) 79 yrs		10 FUND 1 YEAR IF UNDER 24 HRS Months 7 Days 30 Hours 58 Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Probation Officer		10b KIND OF BUSINESS OR INDUSTRY U.S. Government	
11 BIRTHPLACE (State or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas B. Landis		14. MOTHER'S MAIDEN NAME M. Elizabeth Sieber	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO No	
17. INFORMANT Mrs. Goldie E. Landis		Address 2108 Northland Road	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive (cardiovascular) disease DUE TO (b) 7.30-58 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 9-30 p. m. 5-4 19 58		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-30 19 58 to 5-4 19 61 that I last saw the deceased alive on 5-4 19 61 and that death occurred at 10:30 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE William J. Sullivan, M.D.		ADDRESS (Street, city or town, state) 2911 Garrison Boulevard DATE SIGNED 5-14-61	
PHYSICIAN'S NAME (Type) William J. Sullivan, M.D.		2911 Garrison Boulevard	
22a BURIAL, CREMATION REMOVAL (Specify) Burial	22b DATE THEREOF 5/15/1961	22c NAME OF CEMETERY OR CREMATORY Lorraine Cemetery	22d LOCATION (City, town, or county) (State) Baltimore Maryland
23 FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		ADDRESS 4600 Liberty Heights Ave.	
24a REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	



Page 4
after 24 hours after death
ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO HOSPITAL: This certificate may be used for the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9 59

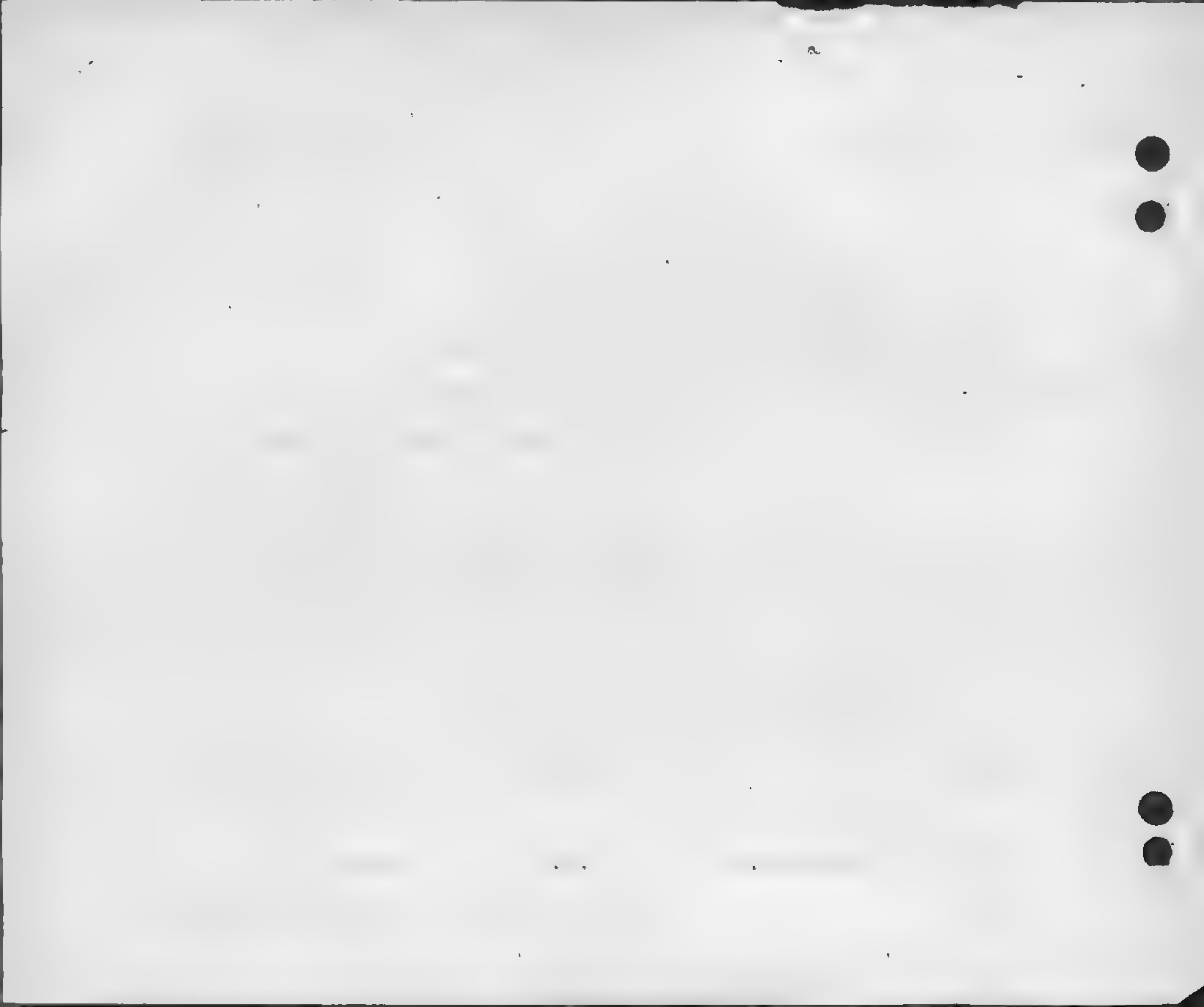
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5277

05269

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c LENGTH OF STAY IN 1b d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1019 Beechfield Avenue		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission, a STATE Md. b COUNTY Baltimore c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d STREET ADDRESS 1019 Beechfield Ave. e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Casimer C. Laukaitis First Middle Last 4 DATE OF DEATH May 7, 1961 Month Day Year 5 SEX male 6 COLOR OR RACE white 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH March 4, 1875 9 AGE in years (last birthday) 86 yrs 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Tailor 10b KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) Russia 12 CITIZEN OF WHAT COUNTRY?			
13 FATHER'S NAME Unknown 14 MOTHER'S MAIDEN NAME Unknown		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 16 SOCIAL SECURITY NO 215-01-5748A 17 INFORMANT Marie Laukaitis Address 1019 Beechfield Ave. #29	
18 CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Arteriosclerosis and atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Arteriosclerosis and atherosclerosis DUE TO Arteriosclerosis and atherosclerosis PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19 Was Autopsy Performed? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4110 20f (City or town) 19 (County) 5/17 (State) 6			
21 I certify that (I) (this hospital) attended the deceased from 4/10 19 61 to 5/17 19 61 that (I) (we) last saw the deceased alive on 5/17 19 61 , and that death occurred at 3:45 AM from the causes and on the date stated above. 22a SIGNATURE Joseph G. Laukaitis, M.D. 22b ADDRESS 679 Washington Blvd. 22c PHYSICIAN NAME (Type) 22d ADDRESS			
23a BURIAL OR CREMATION REMOVAL (Specify) Burial 23b DATE THEREOF 5/10/61 23c NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery 23d LOCATION (City, town or county) Baltimore, Maryland		24 FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard ADDRESS 4107 Wilkens Ave. 25a REC'D BY REGISTRAR MAY 1 1961 25b REGISTRAR'S SIGNATURE CC 84	







5880
CERTIFICATE OF DEATH

Reg. Dist. No.

05272

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OF TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital				d. STREET ADDRESS 1304 Williams St. Catonsville 28			
3. NAME OF DECEASED (Type or print) First August Middle Lettau Last Lettau				4. DATE OF DEATH Month May Day 6 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-10-83	
9. AGE (In years last birthday) yrs 77		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown				10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Bernhardt Lettau				14. MOTHER'S MAIDEN NAME Helena Schadel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 212-10-5476		17. INFORMANT Mr. Lettau, 15 W. West St., Balto., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) CBA with Generalized Arteriosclerosis							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 31, 1959 to May 6, 1961 , that I last saw the deceased alive on May 6, 1961 , and that death occurred at 9:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ricardo Ibanez				ADDRESS (Street, city or town, state) Spring Grove State Hosp. 5-6 61			
PHYSICIAN'S NAME (Type) RICARDO IBANEZ				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 9, 1961		22c. NAME OF CEMETERY OR CREMATORY Landon Park Cemetery		22d. LOCATION (City, town, or county) (State) 3801 Frederick Ave., Balto. 29	
23. FUNERAL DIRECTOR'S SIGNATURE ELYN & FLEMING, INC.				ADDRESS 1422 Light St.		24a. REC'D BY REGISTRAR DATE MAY 9 '61	
24b. REGISTRAR'S SIGNATURE							

Page 4
The law requires that the death certificate be executed within 24 hours of death.
may be used by the hospital or attending physician only.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5281

Item 9 Filed

CERTIFICATE OF DEATH

Reg. Dist No. 15273

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex				c. LENGTH OF STAY IN TB Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 920 Martin Road			
3. NAME OF DECEASED (Type or print) John Richard Lewis First Middle Last				4. DATE OF DEATH May 12 1961 Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 27 1908 67 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Armco Steel		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John T. Lewis				14. MOTHER'S MAIDEN NAME Catherine Goggan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-01-1470			
18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Anterior scloer heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Metastatic Cancer				INTERVAL BETWEEN ONSET AND DEATH 7 YEARS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 18)			
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2/11 1961 to 5/12 1961 that I last saw the deceased alive on 5/11 1961 , and that death occurred at 10 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				DATE SIGNED 4/24 1961			
PHYSICIAN'S NAME (Type) [Signature]							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial May 15 1961				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem				22d. LOCATION (City, town, or county) (State) Baltimore Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Raymond K. Kopyrowski				24a. REC'D BY REGISTRAR DATE MAY 18 '61			
ADDRESS 2525 Fleet St.				24b. REGISTRAR'S SIGNATURE [Signature]			

Page 4 of 4

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. The law requires that the attending physician and completely filled in by the funeral director may be the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

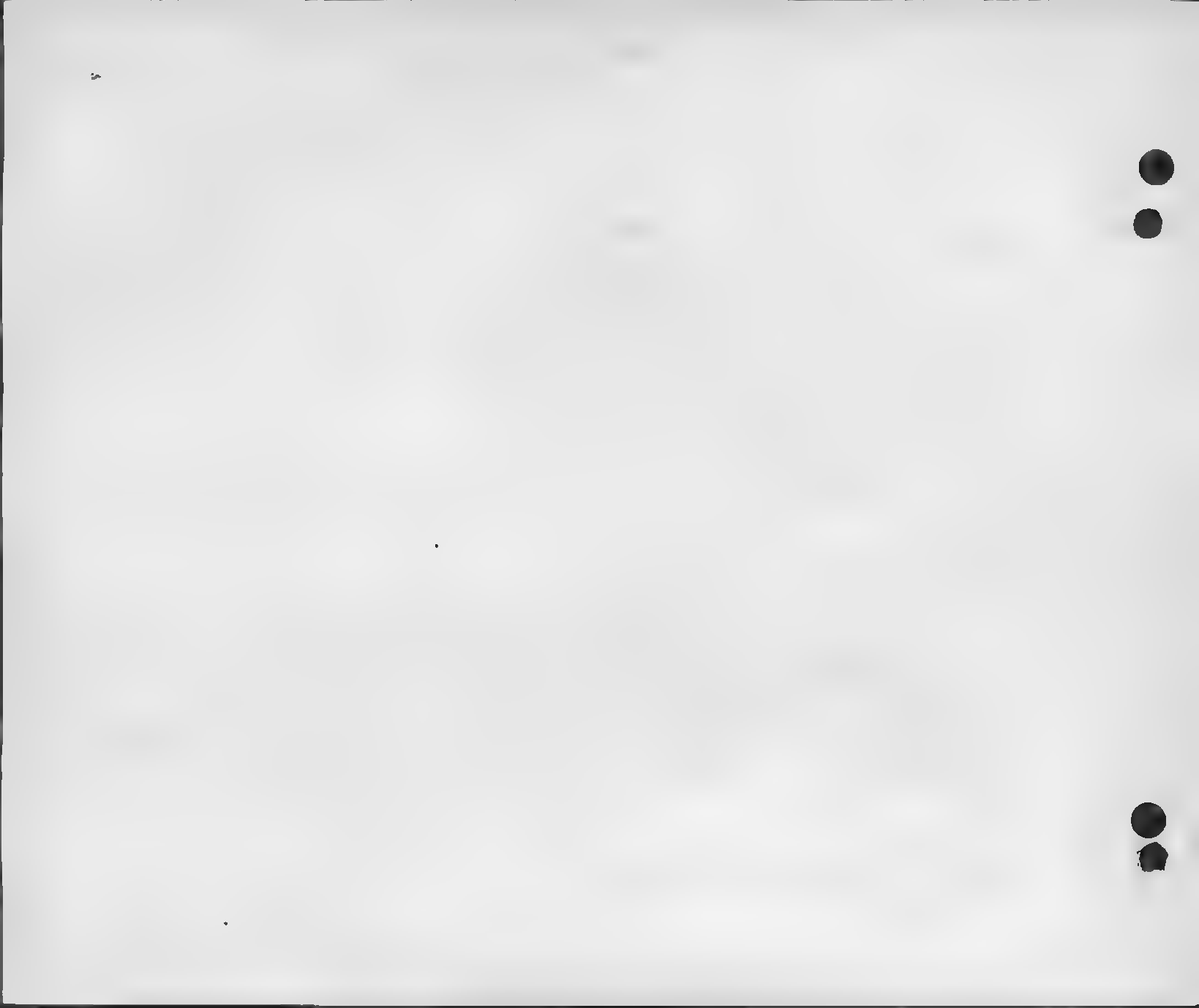
5282

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 45274

1 PLACE OF DEATH a. COUNTY <i>Maryland</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>	c. LENGTH OF STAY IN 1b <i>12 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Home</i>		d. STREET ADDRESS <i>1211 1st St</i>	e. RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <i>Philip</i> Middle <i>Kenneth</i> Last <i>Linville</i>		4. DATE OF DEATH Month <i>May</i> Day <i>22</i> Year <i>1961</i>	
5 SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/6 1949</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	9. AGE (In years last birthday) <i>12 yrs</i>
11 BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13 FATHER'S NAME <i>Philip Linville</i>		14 MOTHER'S MAIDEN NAME <i>Josephine Linville</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>7-14-22-1-25</i>	17. INFORMANT <i>Wife</i> Address <i>1211 1st St</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Unilateral pneumonia</i> DUE TO (b) <i>Aspiration pneumonia</i> DUE TO (c) <i>Aspiration pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 14, 1961</i> to <i>May 22, 1961</i> , that I last saw the deceased alive on <i>May 19, 1961</i> , and that death occurred at <i>2:20 PM</i> , from the causes and on the date stated above			
ACTUAL SIGNATURE <i>Walter T. Kees</i> M.D.		ADDRESS (Street, city or town, state) <i>Hyattsville, Md</i> DATE SIGNED <i>May 22, 1961</i>	
PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>May 22, 1961</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>	22d. LOCATION (City, town or county) (State) <i>Prince George's, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Chapman & Sons</i> ADDRESS <i>1211 1st St</i>		24a. REC'D BY REGISTRAR <i>May 22 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Wm. J. Chapman</i>



SM 9160

TO THE CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. It may be delayed only if the delay is necessary to allow the physician to examine the body. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, and page 4 with the County Board of Health. The body should be buried, cremated, or removed, and in any event within 72 hours after death.



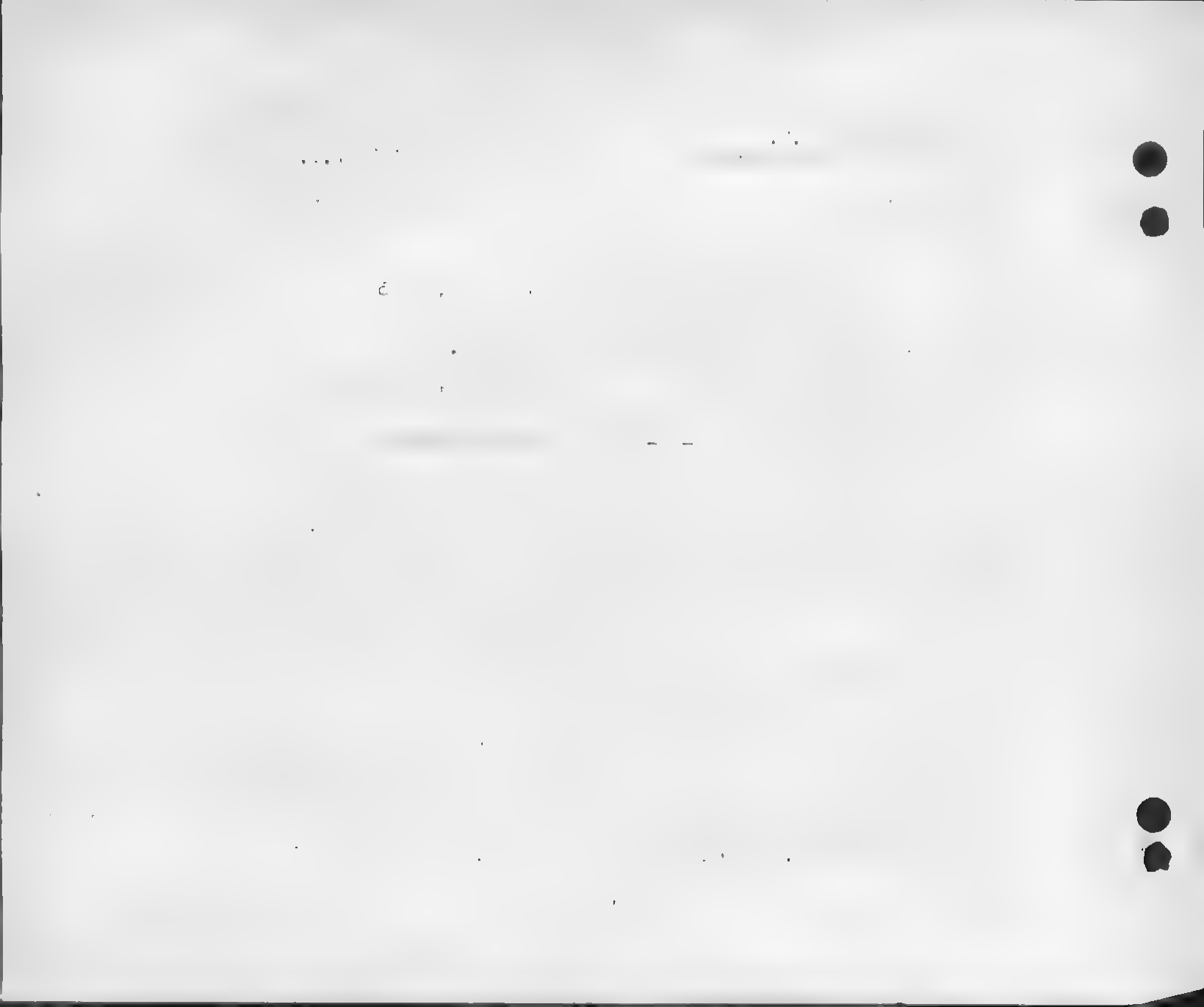
05276

TO HOSPITAL: [REDACTED] ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death with Page 4 may be [REDACTED] the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LS 15M (4)
VS A15 (4)
VS 9/SB

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville P.O.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville P.O.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Greenspring Avenue		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Franklin Last Long		4. DATE OF DEATH Month May Day 10 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1891
9. AGE (In years last birthday) 69 yrs		10. UNDER 1 YEAR: Months 69 11. UNDER 24 HRS: Days 69 Hours 69 Min. 69	
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dairymen - retired		12b. KIND OF BUSINESS OR INDUSTRY Dairy Farm	
13. FATHER'S NAME John Henry Long		14. MOTHER'S MAIDEN NAME Rosella Workman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218032-0256	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) None		18. INFORMANT Family records	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia (terminal) DUE TO 162-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 162-1 (b) Bronchogenic Carcinoma Right Lung DUE TO 162-1 (c) 162-1		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 14 months	
20. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 162-1		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 162-1		22b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) 162-1	
23a. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		23b. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
24a. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 162-1		24b. (City or town) (County) (State) 162-1	
25. I certify that I attended the deceased from March 12, 1954 to May 10, 1961 that I last saw the deceased alive on May 10, 1961 and that death occurred at 10 P.M. from the causes and on the date stated above ADDRESS (Street city or town state) 48 Main Street DATE SIGNED 4-11-61			
ACTUAL SIGNATURE Martin E. Strobel M.D.		ADDRESS (Street city or town state) 48 Main Street	
PHYSICIAN'S NAME (Type) Martin E. Strobel, M.D.		ADDRESS (Street city or town state) Reisterstown, Maryland	
26a. BURIAL, CREMATION REMOVAL (Specify) Burial		26b. DATE THEREOF May 13, 1961	
26c. NAME OF CEMETERY OR CREMATORY Jessop's Cemetery		26d. LOCATION (City town or county) (State) Cockeysville, Maryland	
27. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		28. REC'D BY REGISTRAR MAY 15 '61	
ADDRESS John Burns' Sons, Towson, Maryland		29. REGISTRAR'S SIGNATURE Calvin J. Fraw	



VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

DATE MAY 10 3 14



TO HOSPITAL: 4. The law requires that the death certificate be executed within 72 hours after death. 5. 4. The law requires that the death certificate be executed within 72 hours after death. 6. 4. The law requires that the death certificate be executed within 72 hours after death. 7. 4. The law requires that the death certificate be executed within 72 hours after death. 8. 4. The law requires that the death certificate be executed within 72 hours after death. 9. 4. The law requires that the death certificate be executed within 72 hours after death. 10. 4. The law requires that the death certificate be executed within 72 hours after death. 11. 4. The law requires that the death certificate be executed within 72 hours after death. 12. 4. The law requires that the death certificate be executed within 72 hours after death. 13. 4. The law requires that the death certificate be executed within 72 hours after death. 14. 4. 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I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5286 05278

1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN Baltimore
c. LENGTH OF STAY IN IN MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION 1812 Rushley Road

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence, if not)
a. STATE Md.
b. COUNTY 7
c. CITY OR TOWN Baynesbridge
STREET ADDRESS 1812 Rushley Road

3. NAME OF DECEASED
First John Middle Mader, Sr. Last Mader, Sr.

4. DATE OF DEATH
Month May Day 30 Year 1961

5. SEX male 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐
8. DATE OF BIRTH June 30, 1902

9. AGE (In years) 58 10. OCCUPATION Insurance 11. PLACE OF BIRTH Maryland

12. COUNTRY OF BIRTH USA

13. FATHER'S NAME John Mader 14. MOTHER'S MAIDEN NAME Willner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16. SOCIAL SECURITY NO. 212090607 17. INFORMANT Pearl J. Mader Address 5020

18. CAUSE OF DEATH (Enter on only one cause per line a, b, and c)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE: (a) myocardial infarction
155.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 5/30/61 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Baltimore (County) 7 (State) Md.

21. I certify that (I) (this hospital) attended the deceased from 5/30/61 to 5/30/61, that (I) (the) last saw the deceased alive on 5/30/61, and that death occurred at 11A M, from the causes and on the date stated above

22a. SIGNATURE Stanley B. Klyman 22b. DATE SIGNED 5/20/61
22c. PHYSICIAN'S NAME (Type) 1011 S. East Ave Baltimore, Md.

23a. BURIAL CREMATION REMOVAL (Specify) Burial 23b. DATE THEREOF 5-24-61 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery 23d. LOCATION (City, town or county) Baltimore, Md. State, Md.

24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck ADDRESS 5305 Harford Rd. 25a. REC'D BY REGISTRAR 1 25b. REGISTRAR'S SIGNATURE 1

DATE MAY 23 1961

CERTIFICATE OF DEATH

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>TIMONUM</u>		<u>3445</u>		TOWN <u>TIMONUM</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9. Chesapeake</u>				STREET ADDRESS (If rural give location) <u>9. Chesapeake</u>			
3. NAME OF DECEASED (Type or Print) <u>John H. [unclear]</u> (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>May 24 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10 Nov 1904</u>		9. AGE last birthday <u>56</u> yrs.	10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John H. [unclear]</u>			
14. MOTHER'S MAIDEN NAME <u>Ann [unclear]</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>412 09-1736</u>				17. INFORMANT & ADDRESS <u>W. H. B. [unclear] 9 Chesapeake Rd Timonium</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				5 MIN			
IMMEDIATE CAUSE (A) <u>ACUTE CARDIAC FAILURE</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u>				6 YRS			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>SEPT 1959</u> to <u>MAY 1961</u> , that I last saw the deceased alive on <u>APR 30 1961</u> , and that death occurred at <u>MD 2060 YORK RD TIMONUM MD</u> on the causes and on the date stated above							
SIGNATURE <u>William A. [unclear]</u>				DATE SIGNED <u>5-24-61</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 25 1961</u>		NAME OF CEMETERY OR CREMATORY <u>St. Luke's [unclear]</u>		LOCATION (City, town, or county) (State) <u>Baltimore MD</u>	
24. REC'D BY REGISTRAR <u>MAY 25 '61</u>		REGISTRAR'S SIGNATURE <u>[unclear]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[unclear]</u>		ADDRESS <u>[unclear]</u>	

FOR STATE
HEALTH DEPT.

EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 and 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05280

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN Ctonville c. LENGTH OF STAY IN 5yr7mth10dys
d. NAME OF HOSPITAL SPRING GROVE STATE HOSPITAL

2. USUAL RESIDENCE - Where a deceased lived, if different from place of death
a. STATE Maryland b. COUNTY Prince George's
c. CITY OR TOWN St. Charles, Maryland d. STREET ADDRESS 5309 Gallatin St. N

3. NAME OF DECEASED (Type or print)
First Frank Middle Marsico Last Marsico

4. DATE OF DEATH
Month May Day 9 Year 1961

5. SEX male COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH March 21, 1878

10a. ALLOCATION (Type or print)
10b. KIND OF BUSINESS OR INDUSTRY furnace man 11. BIRTHPLACE (State, foreign or foreign born)
Italy U. S. A.

13. FATHER'S NAME unknown 14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
unknown 16. SOCIAL SECURITY NO. unknown 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute cardiac failure
DUE TO (b) Generalized atherosclerosis.
DUE TO (c) Cardiovascular disease
CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS
Well log tract 1 applied 4-7-61
while getting out of bed sustaining a comminuted intertrochanteric frac. of the right femur.
ON 4-2-61 pt. fell
20. DES. HOW INJURY OCCURRED, nature of injury, if possible
21. TIME OF INJURY
6-4-2-1961
22. PLACE OF INJURY
Hospital
23. TIME OF DEATH
10:16
24. PLACE OF DEATH
Catonsville, Md

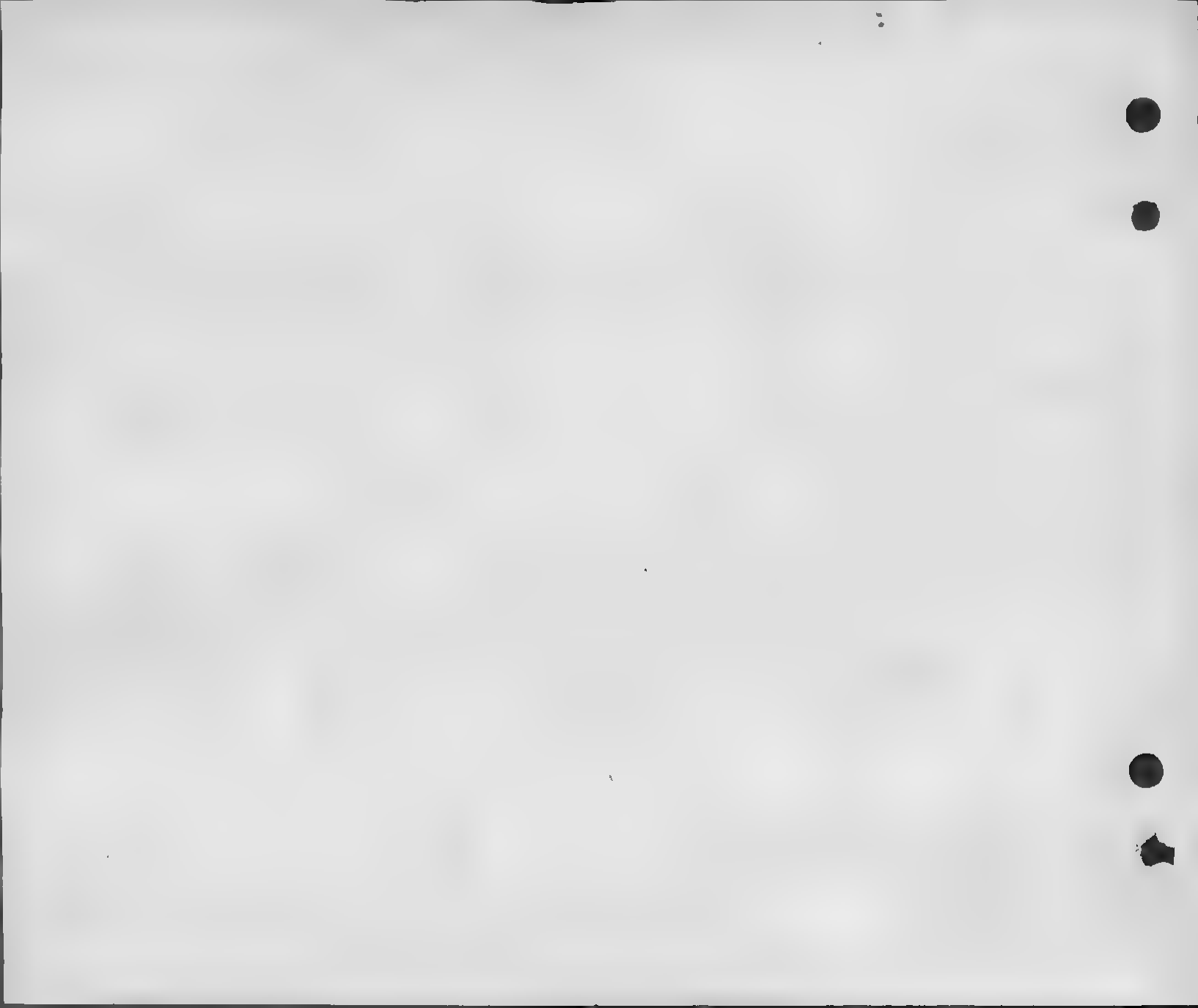
21. I certify that I took charge of the remains described above held in Autopsy ☐ or in ☒ or in ☒
22. Resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Leo M. Kieffer M.D.
EXAMINER'S NAME Leo M. Kieffer, M.D.

24. BURIAL, CREMATION, OR REMOVAL (Specify) Burial 25. DATE THEREOF 5-12-61 26. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem 27. LOCATION (City, town, or county) Bladensburg, Md

23. FUNERAL DIRECTOR W. W. Chambers & Co ADDRESS Prince George's Md 24a. RECD BY REGISTRAR May 12 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Hanes

MEDICAL CERTIFICATION



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05281

1. PLACE OF DEATH
a. COUNTY **Baltimore** MARYLAND
b. CITY OR TOWN (if outside of corporate limits write RURAL and give nearest town) **Catonsville**
c. LENGTH OF STAY IN b. **1184 St. Agnes Lane**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) **House in the Pines**

2. USUAL RESIDENCE When deceased lived first at a. b. c. d.
a. STATE **Md.**
b. COUNTY **Catonsville**
c. CITY OR TOWN (if outside of corporate limits write RURAL and give nearest town) **1184 St. Agnes Lane**
d. STREET ADDRESS **1184 St. Agnes Lane**

3. NAME OF DECEASED (Type or print) **William B. Martin**

4. DATE OF DEATH **May 19/61**

5. SEX **Male**

6. COLOR OR RACE **White**

7. MARRIED ☒ NEVER MARRIED ☐ **April 2, 1884**

8. DATE OF BIRTH **77** yrs.

9. AGE (in years last birthday) **77** yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Plumber**

10b. KIND OF BUSINESS OR INDUSTRY **Baltimore, Md**

11. TEN COUNTRY? **USA**

12. FATHER'S NAME **Benjamin F. Martin**

13. MOTHER'S M. DEN NAME **Bertha Mann**

14. WAS DECEASED EVER IN U.S. ARMED FORCES? **16. SOCIAL SECURITY NO. 17. INFORMANT** **212 03 8540 Mrs. Louise A. Martin, 1184 St. Agnes Lane**

18. CAUSE OF DEATH (Enter only one cause per line for (e) (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE **Crown Thrombosis**
DUE TO **Arterio Sclerosis**
DUE TO **Age**
PART II. OTHER SIGNIFICANT CONDITIONS (OCCURRING PRIOR TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS) **Concussion of Lumbar vertebrae at L4-L5 level**

19. ACCIDENT? **20a. DESCRIBE HOW INJURY OCCURRED** **20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)**

21. I certify that (I) (this hospital) attended the deceased from **July 1952** to **5/19/61** that (I) (we) last saw the deceased alive on **5/3/61**, and that death occurred at **2** M. from the cause and on the date stated above

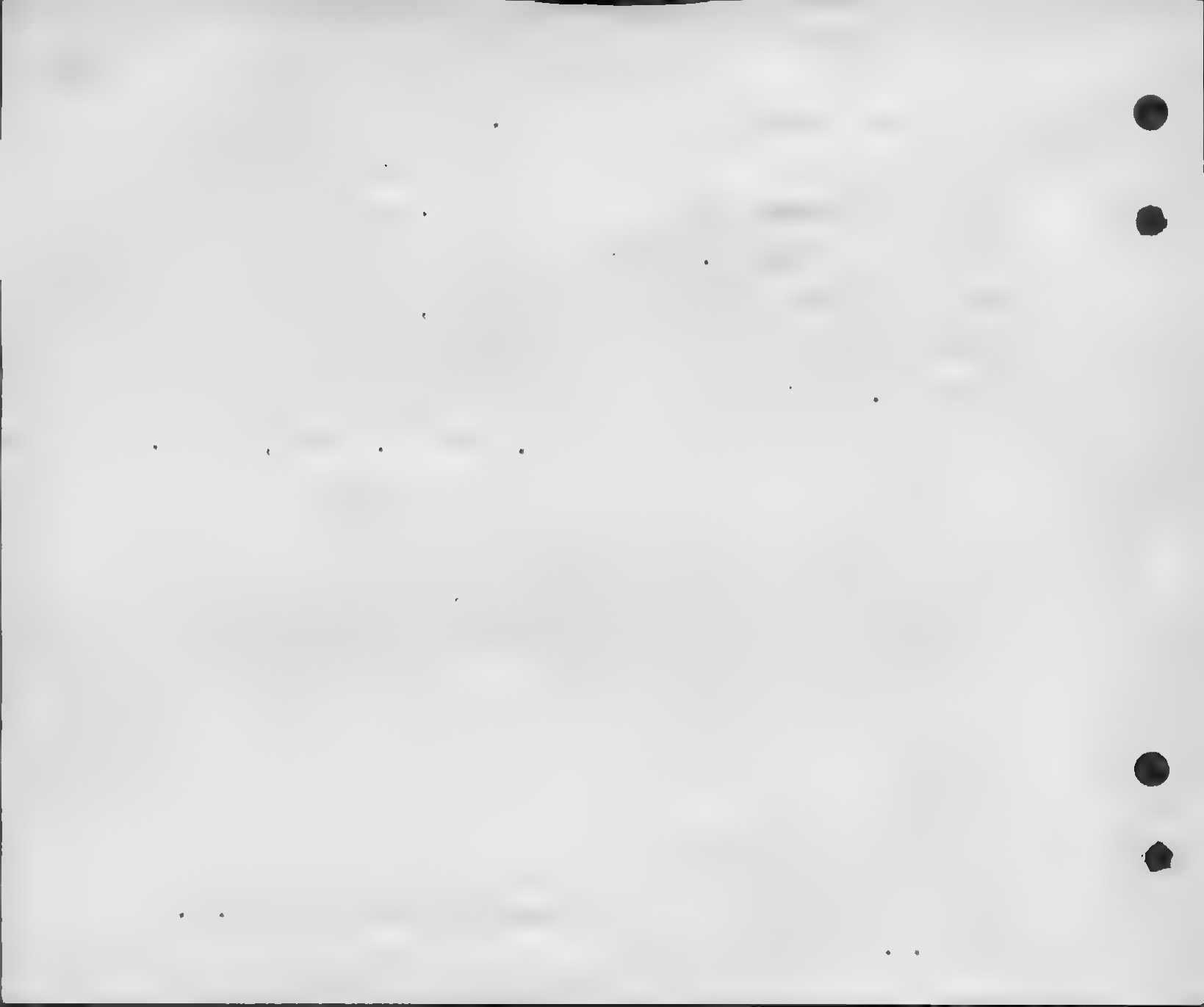
22a. SIGNATURE **CLIFF RATHLEIGH, SR.** ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type) **CLIFF RATHLEIGH, SR.** ADDRESS **4605 EDMONDSON AVE**

23a. BURIAL, CREMATION, 23b. DATE THEREOF **May 22/61** 23c. NAME OF CEMETERY OR CREMATORY **Good Shepherd Cemetery Howard Co. Md.** 23d. LOCATION City, town or county **Witzke A.D. 4101 Edmondson Ave**

24. FUNERAL DIRECTOR'S SIGNATURE **Witzke A.D. 4101 Edmondson Ave** ADDRESS **Witzke A.D. 4101 Edmondson Ave**

25a. REC'D BY REGISTRAR **DATE MAY 22 '61** 25b. REGISTRAR'S SIGNATURE



1 PLACE OF DEATH a COUNTY <u>BALTIMORE</u> b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) _____ c LENGTH OF STAY IN 1b _____ d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>CENT NURSING HOME 12020 S RD 607 W BALTIMORE MD</u>				2 USUAL RESIDENCE (Where deceased lived If institution Residence here) a STATE <u>MARYLAND</u> b COUNTY <u>BALTIMORE</u> c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>BALTIMORE</u> d STREET ADDRESS _____ e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>OTIS H. MASTERS</u>				4 DATE OF DEATH Month Day Year <u>MAY 26 1961</u>			
5 SEX <u>MALE</u>		6 COLOR OR RACE <u>WHITE</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8 DATE OF BIRTH <u>3-8-00</u>			
9 AGE (In years last birthday) <u>61 yrs</u>		10 USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>ENGINEER AT RETIREMENT</u>		11 BIRTHPLACE (State or foreign country) <u>KENTUCKY</u>			
12 CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>				13 FATHER'S NAME <u>THOMAS MASTERS</u>			
14 MOTHER'S MAIDEN NAME <u>SUTHA CORDELL</u>				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>			
16 SOCIAL SECURITY NO. <u>404-18 1071</u>		17 INFORMANT <u>Lillian Masters</u> Address _____					
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Hypertension - from Cannon's</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>None</u>							
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>None</u>					
20c TIME OF INJURY Month Day Year Hour a.m. p.m. _____ 19____		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f (City or town) _____		(County) _____		(State) _____			
21 I certify that () (this has to) attended the deceased from _____ 5/19 1961, to _____ 5/26 1961, that (I) (we) last saw the deceased alive on _____ May 25 1961, and that death occurred at _____ 12:30 PM from the causes and on the date stated above							
22a SIGNATURE <u>George P. McQuinn</u>		22b PHYSICIAN'S NAME (Type) <u>George P. McQuinn MD</u>		22c ADDRESS <u>230 Main St., Westport, Md</u>			
22d DATE <u>May 26, 1961</u>		22e SIGNATURE <u>[Signature]</u>					
23a BURIAL CREMATION REMOVAL (See instructions) <u>Burial</u>		23b DATE THEREOF <u>May 1961</u>		23c NAME OF CEMETERY OR CREMATORY <u>Fairview Park & Burial</u>			
23d LOCATION (City, town, or county) _____		(State) _____					
24 FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Parkway, Rockville, Md</u>		25a RECEIVED BY REGISTRAR <u>[Signature]</u>			
DATE <u>May 28 1961</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>					



TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5283

5291

1. PLACE OF DEATH
a. COUNTY **Baltimore**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Fort Howard**
c. LENGTH OF STAY IN b. **19 Days**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Veterans Administration Hospital**

2. USUAL RESIDENCE (Where dec. had lived if not usual residence, give address)
a. STATE **Maryland**
b. COUNTY **Baltimore**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **100 Newberg Avenue**
d. STREET ADDRESS **100 Newberg Avenue**

3. NAME OF DECEASED (Type or print)
First **FERDINAND** Middle **--** Last **McAVOY**

4. DATE OF DEATH
Month **May** Day **5** Year **1961**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **January 11, 1892** 9. AGE (in years last birthday) **69** 10. IF UNDER 1 YEAR **YES** 11. IF UNDER 2 - HRS **NO**

12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Electrician**
12b. KIND OF BUSINESS OR INDUSTRY **Electrical Contractor**
12c. IF UNDER 2 - HRS **U.S.A.**

13. FATHER'S NAME **John McAvoy** 14. MOTHER'S MAIDEN NAME **Theresa Harvey**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **Yes** 16. SOCIAL SECURITY NO. **216-05-4911** 17. INFORMATION **Clin Rec VAH Baltimore Md - Ft Howard Division**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
(IMMEDIATE CAUSE (a)) **PULMONARY EDEMA**
(b) **CORONARY INSUFFICIENCY**
(c) **3 WEEKS**

19. WAS AUTOPSY PERFORMED? **YES** ☒ **NO** ☐

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.
Encephalomalacia; Hypopituitarism, post operative; Chronic Cholecystitis with Cholelithiasis

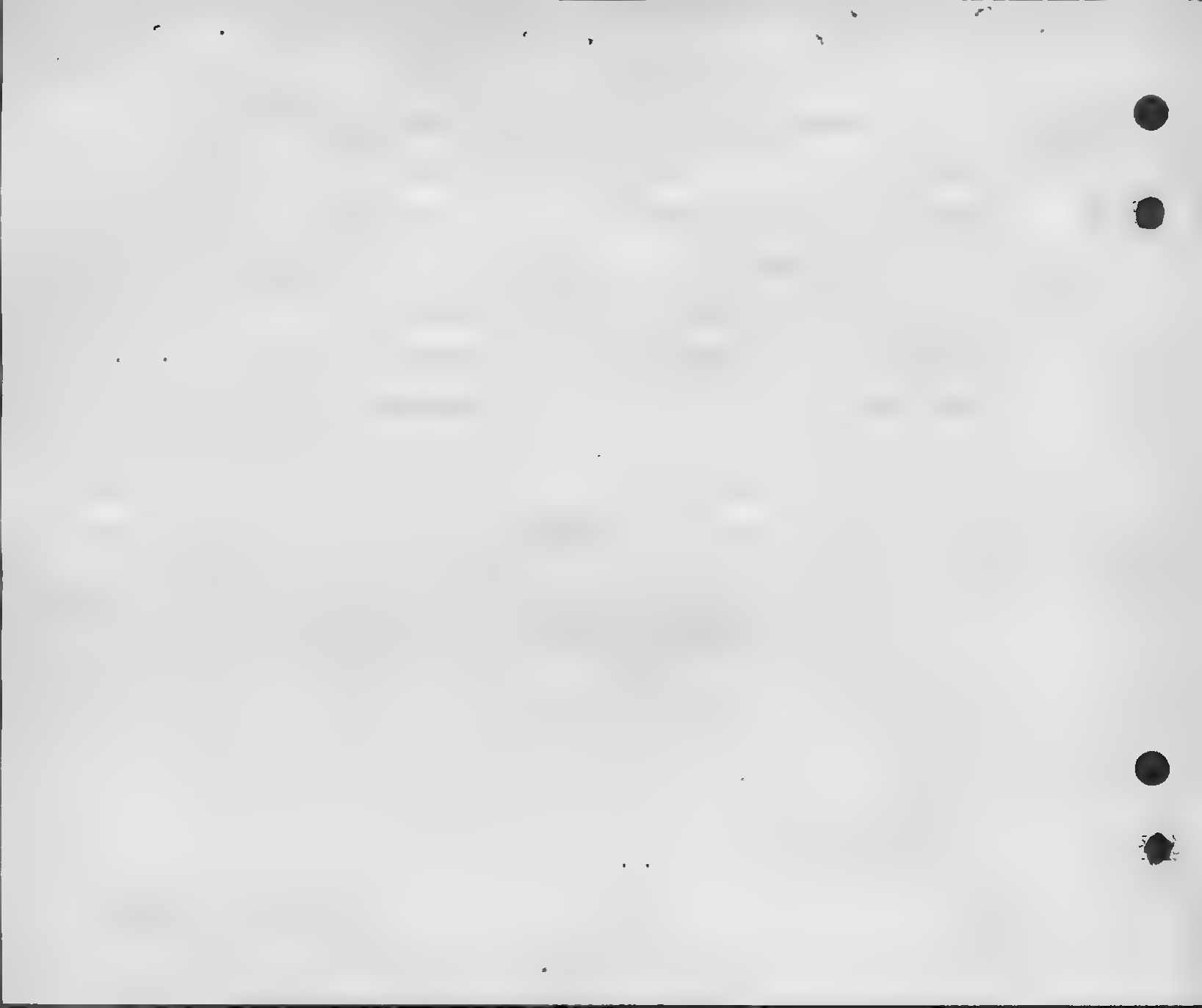
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.) **NO**
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month Day, Year **19** 20d. INJURY OCCURRED **While at work** ☐ **Not While at work** ☐ 20e. PLACE OF INJURY Home farm ☐ City or town ☐ factory, street, office bldg., etc.)

21. I certify that **N** (this hospital) attended the deceased from **April 16, 1961** to **May 5, 1961**, that **N** (we) last saw the deceased alive on **May 5, 1961**, and that death occurred at **2:25 p.m.** from the causes and on the date stated above.

22a. SIGNATURE **Joseph J. Cillo, M.D.** 22b. DATE SIGNED **5-5-61**
22c. PHYSICIAN'S NAME (Type) **Joseph J. Cillo, M.D.** 22d. ADDRESS **VAH Baltimore Md - Ft Howard Division**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **5/4/61** 23c. NAME OF CEMETERY OR CREMATORY **Baltimore National** 23d. LOCATION (City, town or county) **Baltimore** (State) **Maryland**

24. FUNERAL DIRECTOR'S SIGNATURE **MacLabb Funeral Home** 25a. RECORD BY REGISTRAR **5** 25b. REGISTRAR'S SIGNATURE **5**



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05284

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>101 Hill N.H.</u>		e. STREET ADDRESS <u>91 Willow Spring Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Deila</u> Middle <u></u> Last <u></u>		4. DATE OF DEATH Month <u>11</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 5, 1890</u>
9. AGE (in years last birthday) <u>71</u> yrs		10. F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>W.C. Yost</u>		14. MOTHER'S MAIDEN NAME <u>-----</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no print down) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Walter W. McCue, 307 Orlando Ave., Gloucester, N.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>			
DUE TO (b) <u>Arteriosclerosis</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/5/61</u> to <u>11/5/61</u> , that I last saw the deceased alive on <u>11/5/61</u> , and that death occurred at <u>12 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ulrich Funeral Home</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>5-31-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ulrich Funeral Home</u> ADDRESS <u>Dundalk, Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 31 1961</u> 24b. REGISTRAR'S SIGNATURE <u>Charles S. [illegible]</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director may be required by the hospital or attending physician to sign this certificate for use as the burial-transit permit. Pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15285

1. PLACE OF DEATH
a. COUNTY **Baltimore**
b. CITY OR TOWN, (if outside corporate limits, write RURAL and give nearest town) **Fort Howard**
c. LENGTH OF STAY IN 1b **9. Days**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Veterans Administration Hospital**

2. USUAL RESIDENCE Where deceased lived, if not in place of death
a. STATE **Maryland**
b. COUNTY **Queen Annes**
c. CITY OR TOWN, (if outside corporate limits, write RURAL and give nearest town) **Chester**
d. STREET ADDRESS **---**

3. NAME OF DECEASED
First **JAMES** Middle **---** Last **MC DANIEL**

4. DATE OF DEATH
Month **May** Day **15** Year **1961**

5. SEX **Male** 6. COLOR OR RACE **Negro** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **June 1, 1896**

9. Get (in years last birthday) **64** yrs. IF UNDER 1 YEAR Months **---** Days **---** Hours **---** Min. **---**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Laborer** 10b. KIND OF BUSINESS OR INDUSTRY **Waterman** 11. BIRTHPLACE **Chester, Maryland** 12. CITIZEN OF WHAT COUNTRY? **U. S. A.**

13. FATHER'S NAME **Sherman McDaniel** 14. MOTHER'S MAIDEN NAME **Susie Watkins**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? **Yes** 16. SOCIAL SECURITY NO. **WW I** 17. INFORMANT **Clinical Records, Baltimore 18, Md.**

18. CAUSE OF DEATH (Enter on only one cause per 1 for a and b and c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE **PULMONARY INFARCTS, MULTIPLE**
ARTERIOSCLEROTIC HEART DISEASE
DUODENAL ULCER, ACTIVE
DUE TO **---**
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last **---**
DUE TO **---**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH **---** BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I **---**

19. INTERVAL BETWEEN ONSET AND DEATH **RECENT**
UNKNOWN
UNKNOWN

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) **---**

21. I certify that (I) (this hospital) attended the deceased from **5/6/61** to **5/15/61**, that (s) (we) last saw the deceased alive on **May 15** 19**61**, and that death occurred at **4:16 P. M.** from the causes and on the date stated above.

22a. SIGNATURE **Thomas F. Crahan** 22b. DATE SIGNED **5/16/61**

22c. PHYSICIAN'S NAME Type **THOMAS F. CRAHAN, M.D.** 22d. ADDRESS **VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.**

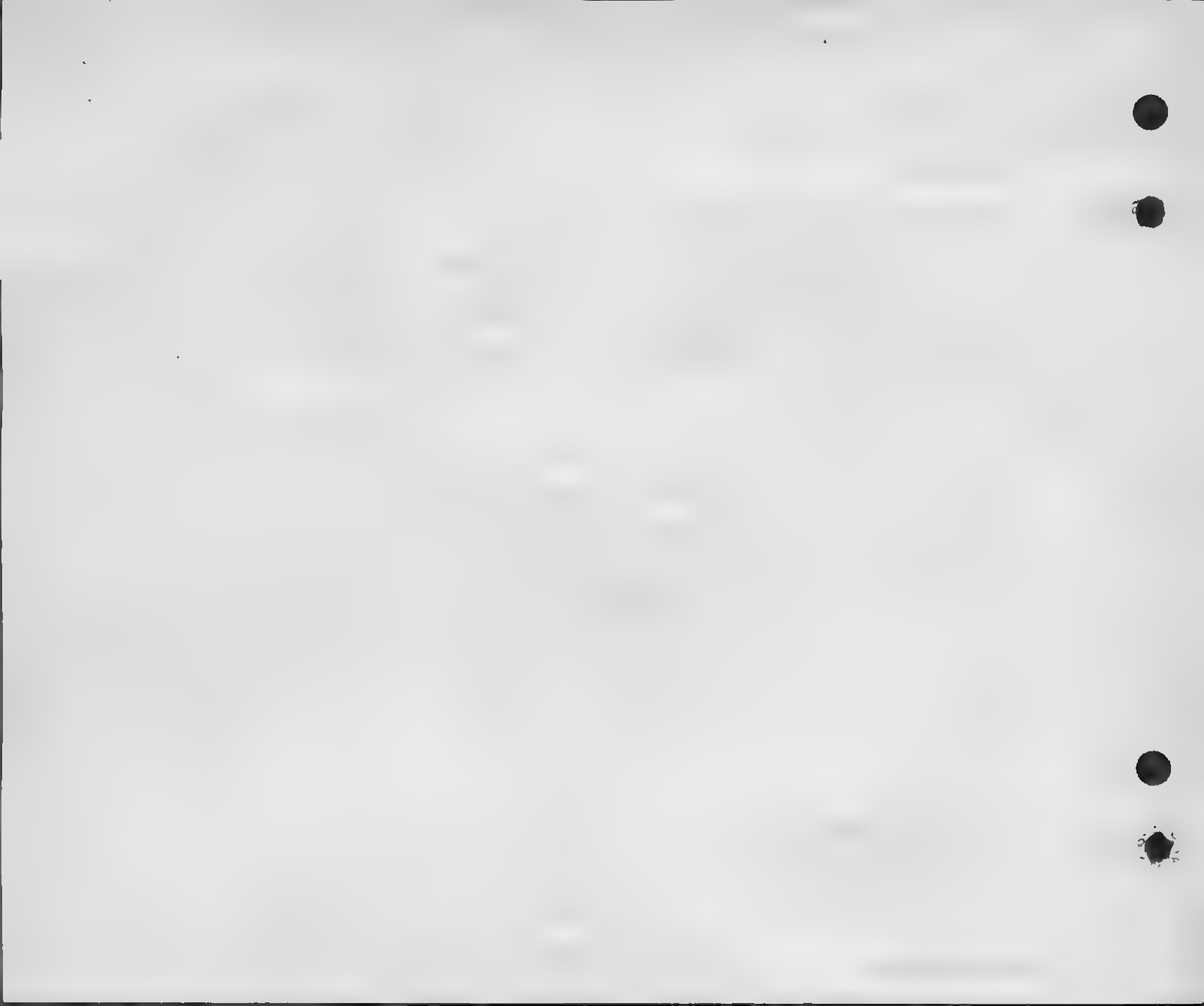
23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **5/26/61** 23c. NAME OF CEMETERY OR CREMATORY **Home Cemetery** 23d. LOCATION (City, town or county, (State) **Chester, Maryland**

24. FUNERAL DIRECTOR'S SIGNATURE **James Dashiell** 25a. REC'D BY REGISTRAR **---** 25b. REGISTRAR'S SIGNATURE **Arthur S. Kraus**

25c. ADDRESS **426 Dover Street, Easton, Maryland** 25d. DATE **MAY 18 '61**

TO HOSE L OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05286

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u>	
d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Warren Road</u>		e STREET ADDRESS <u>Warren Road</u>	
3 NAME OF DECEASED (Type or print) First <u>Norment</u> Middle <u>Henry</u> Last <u>McDonald</u>		4 DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1961</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12 April 1902</u>
9 AGE (in years last birthday) <u>59</u> yrs		IF UNDER 1 YEAR F UNDER 24 HRS Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min <u>15</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11 BIRTHPLACE (State or foreign country) <u>Baltimore City</u>		12 CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13 FATHER'S NAME <u>John Wesley McDonald</u>		14 MOTHER'S MAIDEN NAME <u>Emma Frances Henry</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>213-10-6278</u>	
17 INFORMANT <u>Margaret McDonald wife</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO (b) <u>arterio-sclerotic cardiovascular disease</u> DUE TO (c) <u>6 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> 19 <u>60</u> to <u>May</u> 19 <u>61</u> , that I last saw the deceased alive on <u>14 May</u> 19 <u>61</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Walter T. Kees</u> M.D.		ADDRESS (Street, city or town, state) <u>Cockeysville, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>WALTER T. KEES</u>		DATE SIGNED <u>15 May 1961</u>	
22a BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	22b DATE THEREOF <u>May 18, 1961</u>	22c NAME OF CEMETERY OR CREMATORY <u>Poplar Grove Cemetery</u>	22d LOCATION (City, town, or county) (State) <u>Cockeysville, Maryland</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Maryland</u>		ADDRESS	
24a REC'D BY REGISTRAR		24b REGISTRAR'S SIGNATURE	
DATE <u>May 18 1961</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

VS A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN, if outside corporate limits, write RURAL and give nearest town Catonsville
c. LENGTH OF STAY IN 1b 4 days
d. NAME OF HOSPITAL OR INSTITUTION, if not in hospital, give street address SPRING GROVE STATE HOSPITAL 5021 Williston St.
2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN, if outside corporate limits, write RURAL and give nearest town Baltimore
d. STREET ADDRESS 5021 Williston St.
3. NAME OF DECEASED (Type in full)
First George Middle Ralph Last McKeldin
4. DATE OF DEATH Month May Day 23 Year 1961
5. SEX male 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH May 23, 1886
9. AGE 75 yrs. 10. IF IN U.S. BIRTHDAY 75 yrs. 11. BIRTHPLACE (City or foreign country) U. S. A.
12. AT TIME OF DEATH COUNTRY? U. S. A.
13. FATHER'S NAME UNKNOWN 14. MOTHER'S MAIDEN NAME Catherine Wells
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown 16. SOCIAL SECURITY NO. 705-89-2971 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 0.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) unknown (c) unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (a) NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXT. CAUSE OF DEATH PRIMARY CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED (Enter in full in Part I. If injury occurred at 8:00 p. m. on 5-22-61 patient was struck in the left eye by another patient on the ward causing discoloration of the left eye.
20c. INJURY OCCURRED While at work 20d. PLACE OF INJURY (factory, street, office bldg., etc.) hospital 20e. CITY OR TOWN, STATE Catonsville 20, Maryland
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
ACTUAL SIGNATURE George McKeldin, M.D. ADDRESS (Street, city, town, or county) 1010 Lehigh Ave. Baltimore, Md.
EXAMINER'S NAME (Type) George McKeldin, M.D. ADDRESS (Street, city, town, or county) 1010 Lehigh Ave. Baltimore, Md.
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF May 25, 1961 22c. NAME OF CEMETERY OR CREMATORY New Cathedral 22d. LOCATION (city, town, or country) BALTO. Md.
23. FUNERAL DIRECTOR James L. Larkins ADDRESS 1010 Lehigh Ave. Baltimore, Md.
24a. REC'D BY REGISTRAR Arthur E. Hanna 24b. REGISTRAR'S SIGNATURE Arthur E. Hanna
DATE MAY 25 '61



FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If on duty is deceased, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATE

1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parrows Point, Md.
c. LENGTH OF STAY IN IL
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bethlehem Steel Co. Dispensary

3. NAME OF DECEASED Clyde McKenzie
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 12/5/1900
9. AGE 60 yrs
10. KIND OF BUSINESS OR INDUSTRY Shipbuilding
11. BIRTHPLACE State or foreign country Maryland

13. FATHER'S NAME Alden F McKenzie
14. MOTHER'S MAIDEN NAME Mar Ravenshoft
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Kermit Berg 4714 Meise Drive

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4231 DUE TO Coronary Occlusion
Conditions, if any, which gave rise to immediate cause (b) A.S.C.V. Disease
(c), stating the underlying cause first DUE TO

PART II. PREEXISTING CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR TO THE CAUSE OF DEATH
20a. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of form 1)
20b. TIME OF INJURY NONE
20c. PLACE OF INJURY (Home, farm, factory, street, office, bridge, etc.) NONE
20d. (City or town, street, etc.) NONE

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒
death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Indetermined manner ☐

ACTUAL SIGNATURE Melvin B. Davis, M.D.
EXAMINER'S NAME (Typed)

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 5/4/61
Address: Street, city, town, or county, 6800 Mornington Road

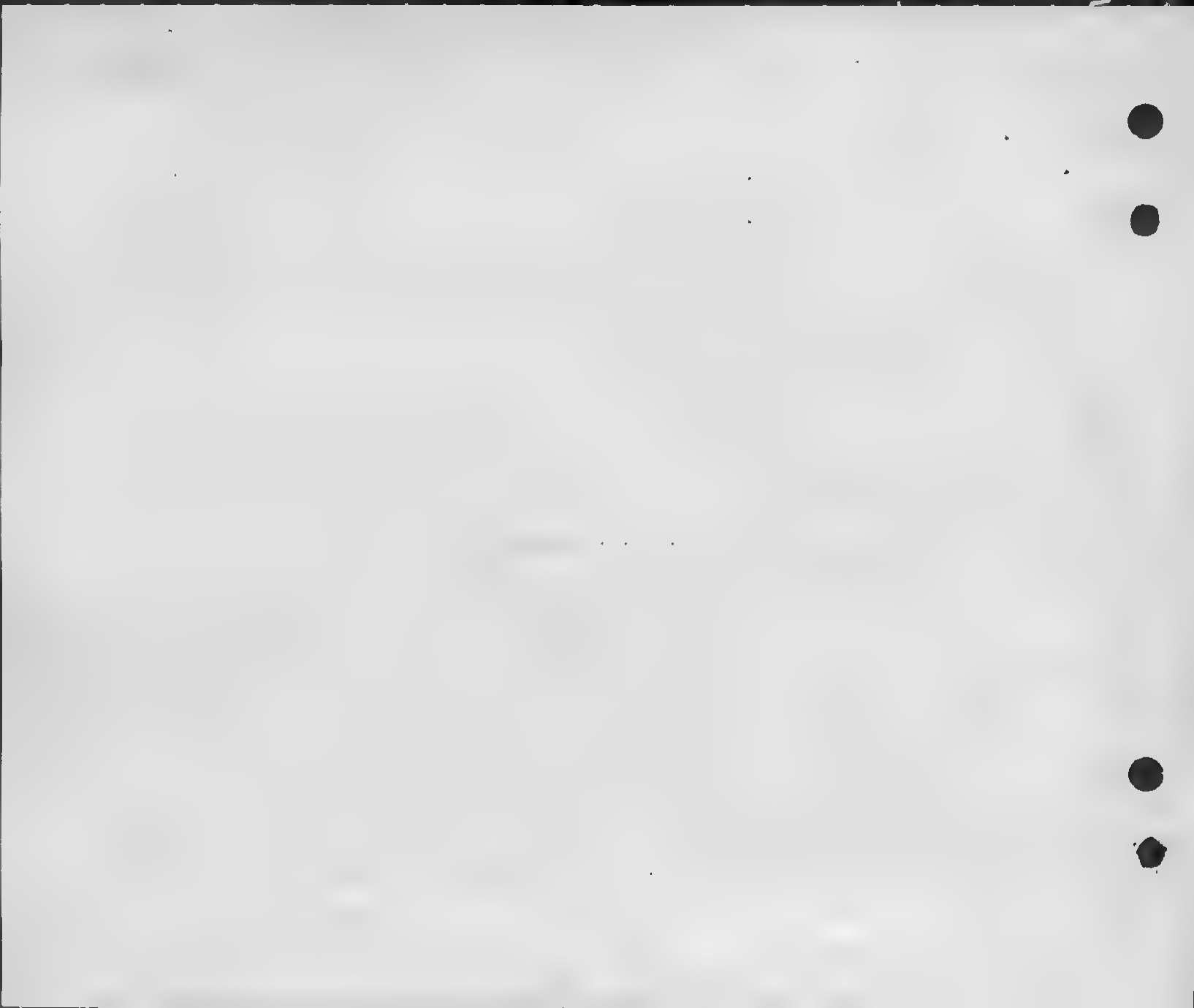
22a. BURIAL, CREMATION, REMOVAL, or other disposition removal
22b. DATE THEREOF May 6/61
22c. NAME OF CEMETERY OR CREMATORY Dawson Cem
22d. LOCATION, city, town, or county Dawson Maryland
23. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road

24a. REC'D BY REGISTRAR
24b. REGISTRAR'S SIGNATURE
DATE MAY 8 '61

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5296 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05288

2. USUAL RESIDENCE (Where deceased lived if not in hospital, Rest Home, etc.)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore-22, Maryland
d. STREET ADDRESS 6817 Belclare Road
e. RESIDENCE ON A FARM? YES ☐ NO ☒
f. DATE OF DEATH May 4 1961
g. SEX Male
h. AGE 60 yrs
i. BIRTHPLACE State or foreign country Maryland
j. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
k. DATE OF BIRTH 12/5/1900
l. KIND OF BUSINESS OR INDUSTRY Shipbuilding
m. BIRTHPLACE State or foreign country Maryland
n. MOTHER'S MAIDEN NAME Mar Ravenshoft
o. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
p. SOCIAL SECURITY NO.
q. INFORMANT Kermit Berg 4714 Meise Drive

ONSET AND DEATH
15 min.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5297

05280

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (if outside corporate limits write BOROUGH and give nearest town)

Catonsville

c. LENGTH OF STAY (in 1b)

2. USUAL RESIDENCE Where deceased lived, if not in U.S. If in U.S. give county and city or town

a. STATE

b. COUNTY

MD

Baltimore

c. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town)

Catonsville

d. STREET ADDRESS

5701 Johnnycake

10. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

ANNA E. MEEHAN

4. DATE OF DEATH

May 5 1961

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH

6/18/86

9. AGE (In years IF UNDER 1 YEAR F UNDER 4 HRS. last birthday) Months Days Hours Min

74 yrs.

10a. USUAL OCCUPATION (Active kind of work done during most of working life, even if retired)

Homemaker

10b. KIND OF BUSINESS OR INDUSTRY

Homemaker

11. BIRTH PLACE County & State or foreign country

MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Michael Meehan

14. MOTHER'S MAIDEN NAME

Elizabeth Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? ☐ YES, no or unknown (If so give year or dates of service)

No

16. SOCIAL SECURITY NO ☐ IF INFORMANT Address

Elizabeth Meehan

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1-01 DUE TO

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last.

CORONARY THROMBOSIS

ARTERIO-SCLEROTIC HEART-DISEASE

(b)

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

County

(State)

21. I certify that (I) (the hospital) attended the deceased from *1/1* 19*58*, to *5/5* 19*61*, that (I) (we) last saw the deceased alive on *5/5* 19*61*, and that death occurred at *8:30 PM* on the causes and on the date stated above

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

John H. Shalmon

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22d. ADDRESS

22b. DATE SIGNED

5/5/61

23a. BURIAL, CREMATION REMOVAL (Specify)

23b. DATE THEREOF

5/8/61

23c. NAME OF CEMETERY OR CREMATORY

Good Shepherd

23d. LOCATION (City, town or county)

Staten Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

28

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

MAY 9 '61

Clifford S. Kraus

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a physician, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 7/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5299

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission.)
a. STATE Md b. COUNTY Balto
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED
Type FRED MENGES MILLER
First Middle Last
4. DATE OF DEATH September 8, 1961 1961
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH September 8, 1906 1906
9. AGE In 55 yrs. FINGER 1 AS 1 IR 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secty & Vice Pres. Miller Bros. Restaurant
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTH PLACE (State or foreign country) Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John H. Miller 14. MOTHER'S MAIDEN NAME Sarah Virginia Marr
15. WAS DECEASED EVER IN U.S. ARMED FORCES? ☐ 16. SOCIAL SECURITY NO. 43-45360-07-2-11-1 17. INFORMANT Arthur L. Hines
(Yes, no, or unknown) (If yes, give war or dates of service) Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) None
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONFIRMING SYMPTOMS)
19. PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. None
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Sept 8, 1961 20d. INJURY OCCURRED While at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) City (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE C. L. Cattle M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) C. L. CATTLE ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF May 5, 1961 22c. NAME OF CEMETERY OR CREMATORY Greenmount Maysoleum 22d. LOCATION (City, town, or county, state) Baltimore Md.
23. FUNERAL DIRECTOR HENRY SANDER & SONS, INC. Baltimore Md. ADDRESS
24a. REC'D BY REGISTRAR MAY 4 '61 24b. REGISTRAR'S SIGNATURE Arthur L. Hines



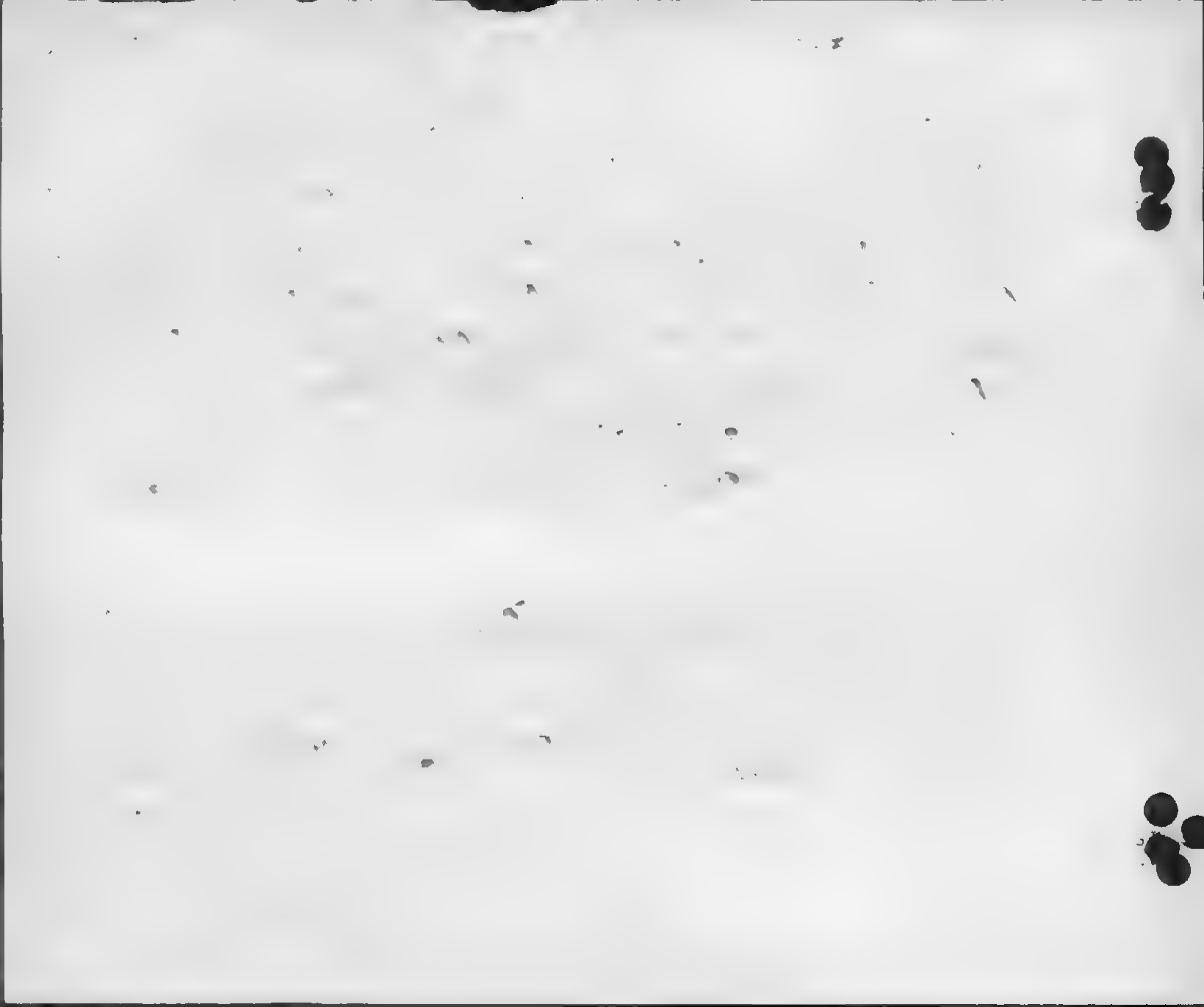
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05292

1 PLACE OF DEATH a. COUNTY <u>ANN</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Reside a before admiss on) a. STATE <u>MARYLAND</u> b. COUNTY <u>ESSEX</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANN</u>		c. LENGTH OF STAY IN 1b <u>15 MONTHS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>109 RIVERSIDE ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>ELLSWORTH SEDELA MOFFITT</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>21</u> Year <u>1961</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>APRIL 21 1873</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PROPRIETOR BOAT YARD</u>		10b KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	9 AGE (in years) lost birthday <u>36</u> yrs
11 BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>ROBERT MOFFITT</u>		14 MOTHER'S MAIDEN NAME <u>ANN RICHARD</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16 SOCIAL SECURITY NO. <u>213-34-1450</u>	
17 INFORMANT <u>Hospital Records, Mt. Wilson State Hospital</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PULMONARY TUBERCULOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21 I certify that (I) (this hospital) attended the deceased from <u>FEB 25 1961</u> to <u>MAY 21 1961</u> that (I) (we) last saw the deceased alive on <u>MAY 21 1961</u> and that death occurred at <u>7:45</u> M. from the causes and on the date stated above			
22a. SIGNATURE <u>W. H. HARRIS</u>		22b. DATE SIGNED <u>MAY 21 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. H. HARRIS, M.D., Superintendent</u>		22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, N.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-25-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CAK LAWN</u>		23d. LOCATION (City, town, or county) <u>BALTO. CC</u> (State) <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connolly</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 23 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>DATE MAY 23 '61</u>			

(M)

(I)



MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57

3

3

ENDING PHYSICIAN: The law requires that the death certificate be executed with n 24
the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10
5302
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15291

1 PLACE OF DEATH a COUNTY <u>BALTIMORE</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE <u>MD.</u> b COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>438 OVERBROOK RD</u>				d STREET ADDRESS <u>438 OVERBROOK RD</u>			
3 NAME OF DECEASED (Type or print) <u>CHARLES FRANCIS MORRISON</u>				4 DATE OF DEATH <u>MAY 29, 1961</u>			
5 SEX <u>M.</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>NOV. 20, 1877</u>	9 AGE (In years, less birthday) <u>83</u> yrs	F UNDER 1 YEAR Months Days		F UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT</u>		11 BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES MORRISON</u>				14 MOTHER'S MAIDEN NAME <u>IDA STEVENSON</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16 SOCIAL SECURITY NO.		17 INFORMANT <u>MRS SOPHIA B. MORRISON, 438 OVERBROOK RD.</u>			
18 CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leukemia, myeloid, subacute</u> DUE TO (b) _____ Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Arteriosclerotic Cardio-vascular Disease</u>							
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Hour a m p m		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)		20f (City or town) (County) (State)	
21 I certify that (1) <u>Leopold J. Gaver, M.D.</u> attended the deceased from <u>March 1949</u> to <u>May 1961</u> that (1) <u>Leopold J. Gaver, M.D.</u> saw the deceased alive on <u>March 27, 1961</u> and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above							
22a SIGNATURE <u>Leop J. Gaver, M.D.</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>May 29, 1961</u>	
22c PHYSICIAN'S NAME (Type) <u>Leop J. Gaver, M.D.</u>				22d ADDRESS <u>1 Mallow Hill Ave., Baltimore 29, Md.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City, town or county) State	
<u>INTERMENT</u>		<u>MAY 31/61</u>		<u>LOBBRAINE PK.</u>		<u>WOODLAWN MD.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>WITTE FUN. DIR. 4101 EDMONDSON AVE.</u>				25a REC'D BY REG. STRAR		25b REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

Reg. Dist. No.

295

1 PLACE OF DEATH a. COUNTY Baltimore Co. MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12 Greenwood Ave. Balto, 6, Md		e. STREET ADDRESS 12 Greenwood Ave Balto. 6, Md	
3. NAME OF DECEASED (Type or print) First Stephen Middle Morowski Last (Murovski)		4. DATE OF DEATH Month May Day 13 Year 1961	
5 SEX M	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/26/1901
9 AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months 6 Days 13 Hours 13 Min 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Tailoring	
11 BIRTHPLACE (State or foreign country) Lithuania		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME George Murovski		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-09-4363	
17. INFORMANT Josephine Morowski		Address 12 Greenwood Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, Generalized DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tuberculosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 13, 1958 to May 13, 1961 , that I last saw the deceased alive on May 12, 1961 , and that death occurred at 1200A M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Charles A. Sevcik M.D.			
PHYSICIAN'S NAME (Type) Dr. Charles Sevcik		5101 Belair Rd.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5/16/61	
22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John ...		24a. REC'D BY REGISTRAR DATE MAY 1	
24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used for the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

20

21

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5304

15296

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived first 100 or Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Lutherville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>College Manor</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Dagenast</u> Last <u>Towson</u>				4 DATE OF DEATH Month <u>5</u> Day <u>2</u> Year <u>1961</u>			
5 SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>4-17-1868</u>	
9 AGE (In years last birthday) <u>93</u> yrs		F UNDER 1 YEAR Months <u>7</u> Days <u>1</u>		F UNDER 24 HRS Hours <u>1</u> Min <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant Tailoring</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
13 FATHER'S NAME <u>Henry Dagenast</u>				14 MOTHER'S MAIDEN NAME <u>Catherine Louise Freese</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16 SOCIAL SECURITY NO. <u>none</u>		17 INFORMANT <u>E. Pressmann R.N.</u> Address	
18 CAUSE OF DEATH [Enter on any one cause per line for (a), (b) and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u>							
DUE TO (b) <u>Arterio Sclerotic Vascular Disease</u>							
DUE TO (c) _____							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: _____							
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour o m p m _____ 19____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21 I certify that (I) (this hospital) attended the deceased from <u>June 1, 1957</u> to <u>May 2, 1961</u> that (I)-(we) last saw the deceased alive on <u>5/1/61</u> 19____ and that death occurred at <u>12:45 PM</u> from the causes and on the date stated above							
22a. SIGNATURE <u>H. M. Conway</u>				22b. DATE SIGNED <u>5/1/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>H. M. Conway MD</u>				22d. ADDRESS <u>R318 Loc. Rm. Bldg. 10 - 4th</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/6/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		23d. LOCATION (City, town, or county) <u>BALTIMORE</u> (State) <u>MD.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>LEONARD J. RUCK</u>				25a. REC'D BY REG STRAR <u>5365 HARFORD Rd.</u> 25b. REG STRAR'S SIGNATURE _____ DATE <u>May 1 1961</u>			

MEDICAL CERTIFICATION

ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death by a physician who has attended the deceased or the attending physician and completely filled in the certificate. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



5305

CERTIFICATE OF DEATH

Reg. Dist No.

05297

Page 4

TO HOSPITAL: The attending physician and the funeral director must sign this certificate. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1 PLACE OF DEATH a. COUNTY <u>Balt</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balt</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - BALTO.</u>		c LENGTH OF STAY IN lb <u>39</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>921 Leeds Ave.</u>		e. STREET ADDRESS <u>BALTO 27 Md</u>	
3 NAME OF DECEASED (Type or print) <u>BEULAH MARIETTE NEAL</u>		4 DATE OF DEATH <u>MAY 29 1961</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>21 Dec 1905</u>
9 AGE (In years and months) <u>55</u>		10 FUNDING YEAR IF UNDER 24 HRS <u>Months Days Hours Min</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Sailor</u>	
11 BIRTHPLACE (State or foreign country) <u>BALTO - Md</u>		12 CITIZEN OF WHAT COUNTRY? <u>U S</u>	
13 FATHER'S NAME <u>WALTER SMITH</u>		14 MOTHER'S MAIDEN NAME <u>Ella DAY</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? <u>no</u>		16 SOCIAL SECURITY NO <u>218-26-2827</u>	
17 INFORMANT <u>Husband - 921 LEEDS-AVE</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>10 yrs</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a. m. p. m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY Home farm factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1951</u> to <u>29 May 1961</u> , that I last saw the deceased alive on <u>Dec 1961</u> , and that death occurred at <u>7A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Goodman</u> M.D. 1334 Sulphur Spring Rd 29 MAY 61		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>WILLIAM GOODMAN MD</u>		<u>Balto 29 Md.</u>	
22a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-1-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>		ADDRESS	
24a REC'D BY REGISTRAR		24b REGISTRAR'S SIGNATURE	



ENDING PHYSICIAN: The low requires that the death certifi cate be executed within 24 h th. Page 4
may be t is the hospital or attending physic an
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physic on and completely filled in by the eroid rector
page 3 should be detached for use as the bur of transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation or removal, and in any event within 72 hours after death

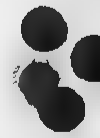


5306

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15298

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Joseph's Hospital</u>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> d. STREET ADDRESS <u>PFISTER TRAILER PARK</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>STEVEN</u> Last <u>NEWYHR</u>		4. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-12-1894</u>
9. AGE (In years last birthday) <u>66</u> yrs		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>29</u> Hours <u>19</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTENDANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRED NEWYHR</u>		14. MOTHER'S MAIDEN NAME <u>ELLA MC CORMICK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Michael Wilson</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>PULMONARY TUBERCULOSIS</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>11-10</u> 19 <u>60</u> to <u>5-29</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>5-24</u> 19 <u>61</u> and that death occurred at <u>7P</u> M from the causes and on the date stated above			
22a. SIGNATURE <u>Michael Wilson</u>		22b. DATE SIGNED <u>—</u>	
22c. PHYSICIAN'S NAME (Type) <u>Michael Wilson</u>		22d. ADDRESS <u>—</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/3/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City, town or county) <u>Colmar Manor, Md.</u> State <u>—</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>—</u>		25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>Colman & Kious</u>	
ADDRESS <u>Hyattsville Md.</u>		DATE <u>JUN 2 '61</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

05299

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale c. LENGTH OF STAY IN 1b Rockdale d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3514 Rolling Road		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale d. STREET ADDRESS 3514 Rolling Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LIZZIE MAY NORRIS		4. DATE OF DEATH Month Day Year May 7 19 61	
5 SEX Female	6 CO. OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 31, 1875
9 AGE (in years last birthday) 85 yrs		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Harford Co., Maryland	
11. BIRTHPLACE (State or foreign country) USA		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rufus Lowe		14. MOTHER'S MAIDEN NAME Rachael Marsteller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Dorothy Gosnell-3514 Rolling Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Failure Conditions of any which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o m p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 7, 19 61 , to May 7, 19 61 , that I last saw the deceased alive on May 7, 19 61 , and that death occurred at 4:30 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) 9017 Liberty Rd. Randallstown, Md. DATE SIGNED			
ACTUAL SIGNATURE John J. Darrell		M.D. 7019 Liberty Road	
PHYSICIAN'S NAME (Type) John J. Darrell, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/11/1961	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Woodlawn Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		24a. REC'D BY REGISTRAR May 11 '61	24b. REGISTRAR'S SIGNATURE Arthur P. Kneass

1

ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The attending physician and completely filled in by the funeral director may be registered by the hospital or attending physician. After this certificate has been signed by the funeral director, the certificate should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5308

05300

1. PLACE OF DEATH
a. COUNTY **Baltimore** b. CITY OR TOWN **Lutherville** c. LENGTH OF STAY IN b. **2 yrs.**

2. USUAL RESIDENCE (Where dec. died, if institution, give name)
a. STATE **Md.** b. COUNTY **Baltimore** c. CITY OR TOWN **Ruxton**

3. NAME OF DECEASED (Type or print)
First **Estelle** Middle **Marshall** Last **Oliver**

4. DATE OF DEATH
Month **May** Day **16** Year **1961**

5. SEX **F** 6. COLOR OR RACE **W** 7. MARRIED ☐ NEVER MARRIED ☐ B. DATE OF BIRTH **11-4-1882**

8. AGE (In years last birthday) **78** yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.

9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife** 10. KIND OF BUSINESS OR INDUSTRY **Maryland**

11. CITIZENSHIP **USA**

12. FATHER'S NAME **John W. Marshall** 13. MOTHER'S MAIDEN NAME **Agnes Dolan**

14. WAS DECEASED EVER IN U.S. ARMED FORCES? **no** 15. SOCIAL SECURITY NO. **no** 16. INFORMANT **Mrs. Benjamin Rutledge** Address **Above**

17. CAUSE OF DEATH (Enter only one cause per line for fatal cause)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE a. **Cerebral vascular accident**
b. **Arteriosclerosis**
c. **2 YRS. 2ND EPISODE 3 DAYS**

18. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: **no**

19. A. INCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER **no** 20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

21. TIME OF INJURY Month, Day, Year **1959** 22. INJURY OCCURRED While at work ☐ Not While at work ☐ 23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **5th** 24. (City or town) **Baltimore** (County) **Md.** (State)

25. I certify that (I) **Carlton L. Sexton** attended the deceased from **FEB. 1959** to **MAY 16, 1961**, that (I) **no** saw the deceased alive on **MAY 14 1961**, and that death occurred at **5 PM** from the causes and on the date stated above

26. SIGNATURE **Carlton L. Sexton** M.D. 27. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 28. DATE SIGNED **May 16, 1961**

29. PHYSICIAN'S NAME (Type) **Carlton L. Sexton, M.D.** 30. ADDRESS **819 Park Avenue, Baltimore 1, Md.**

31. BURIAL CREMATION REMOVAL (Specify) **Crementation** 32. DATE THEREOF **5-18-61** 33. NAME OF CEMETERY OR CREMATORY **Greenmount** 34. LOCATION (City, town or county) **Baltimore** State **Md.**

35. FUNERAL DIRECTOR'S SIGNATURE **H.W. Jenkins & Sons Co.** ADDRESS **4905 York Rd.** 36. REC'D BY REGISTRAR **MAY 22 '61** 37. REGISTRAR'S SIGNATURE **Arthur L. Thomas**

TO HOPE: The law requires that the death certificate be executed by a physician after death. Pages 4 and 5 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5309

05301

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Fort Howard
c. LENGTH OF STAY IN 70 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital

2. NAME OF DECEASED (Type or print) First Middle Last JOHN --- O'NEILL
3. SEX Male 4. DATE OF DEATH May 10 19 61
5. COLOR OR RACE White 6. MARRIED ☒ NEVER MARRIED ☐
7. DATE OF BIRTH January 9, 1885 8. AGE in years 76 9. IF UNDER 1 YEAR IF UNDER 2 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Philadelphia, Pennsylvania U. S. A.
11. FATHER'S NAME Tom O'Neill 12. MOTHER'S MAIDEN NAME Mary Bradley
13. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes 14. SOCIAL SECURITY NO. WW I 15. INFORMANT Address Clinical Records, VAH, Baltimore, Maryland
16. CAUSE OF DEATH (Enter only one cause per line for a, b, and c)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE a. BRONCHOPNEUMONIA
b. PULMONARY TUBERCULOSIS, HEALING
c. EMPHYSEMA
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE LONG TERM GIVEN IN PART I
1. Carcinoma of trachea, Post-operative, duration unknown
2. Arteriosclerosis, marked, generalized
20a. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month Day Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
21. I certify that (If this hospital) attended the deceased from March 1, 1961, to May 10, 1961, that (I) (we) last saw the deceased alive on May 10, 1961, and that death occurred at 5:00 P.M. from the causes and on the date stated above
22a. SIGNATURE 22b. DATE 5/11/61
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.
22d. ADDRESS VAH, Baltimore 18, Maryland
22e. FORT HOWARD DIVISION
23a. BURIAL, CREMATION, 23b. DATE THEREOF Removal 5-11-61 23c. NAME OF CEMETERY OR CREMATORY Beverly National Cemetery, New Jersey
23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. 14, Md. DATE MAY 10 1961
25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/25/61	22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith	22d. LOCATION (City, town, or county) Baltimore, Maryland	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22		ADDRESS	24a. REC'D BY REGISTRAR DATE MAY 24 '61	24b. REGISTRAR'S SIGNATURE <i>W. B. Bradley</i>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

05303

1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard
c. LENGTH OF STAY IN 1b 53 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1453 Mountmor Court

3. NAME OF DECEASED (Type or print)
First ED Middle - - - Last PARKER

4. DATE OF DEATH
Month May Day 20 Year 1961

5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH
Month March Day 30 Year 1897

9. AGE (in years, if under 1 year, give under 24 hrs.)
last birthday | Months | Days | Hours | Min. 64 yrs.

10a. USUAL OCCUPATION, Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Brick Yard
11. BIRTHPLACE Country & State, or foreign country Gretna, Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Beverly Parker 14. MOTHER'S MAIDEN NAME Sarah Edwards

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW-1
16. SOCIAL SECURITY NO. 214-22-3665 17. INFORMANT Clinical Records, 3900 Loch Raven Blvd. Balto 1, Md. - FORT HOWARD DIVISION

18. CAUSE OF DEATH (Enter only one cause, or for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA
(b) CONGESTIVE HEART FAILURE
(c) HYPERTROPHY AND DILATATION OF THE HEART
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last, Carcinoma of rectum (1942)
PART II. THE GRAVE AND CONDITIONS CONTRIBUTING TO DEATH (NOT RELATED TO THE TERMINAL ILLNESS OR CONDITION OF DECEASED)
INTERVAL BETWEEN ONSET AND DEATH 0 days
INTERVIEW PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 1961 May 20
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY Home farm factory, street, office bldg, etc.] VAH Fort Howard, Maryland

21. I certify that (X) (this hospital) attended the deceased from March 28, 1961 to May 20, 1961 that (X) (we) last saw the deceased alive on May 20, 1961 and that death occurred at 5:30 P.M. from the causes and on the date stated above

22a. SIGNATURE Armen Bogosian 22b. DATE SIGNED 5/21/61
22c. PHYSICIAN'S NAME (Type) ARMEN BOGOSIAN, M.D. 22d. ADDRESS VAH Fort Howard, Maryland

23a. BURIAL, CREMATION, 23b. DATE THEREOF Burial 5-25-61 23c. NAME OF CEMETERY OR CREMATORY Baltimore National 23d. LOCATION (City, town or county) Baltimore (State) Maryland

24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips 25a. REC'D BY REGISTRAR MAY 25 '61 25b. REGISTRAR'S SIGNATURE Arleton S. Phillips

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician for 4 years. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60



TO HO... ATTENDING PHYSICIAN. The law requires that the death certificate be executed... 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
312
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
05304

1. PLACE OF DEATH
a. COUNTY Baltimore **MARYLAND**
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonville
c. LENGTH OF STAY IN IL 1
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Home in the Pine Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonville
d. STREET ADDRESS 5720 East Venable e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last
4. DATE OF DEATH May 15 1961 Month Day Year

5. SEX Male **6. COLOR OR RACE** White **7. MARRIED** ☐ NEVER MARRIED ☐ B. DATE OF BIRTH Aug 15 1906 **9. AGE** (In years, last birthday, Months, Days, Hours, Min) 54 yrs 11 mos 1 day 2 hrs **10. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) Housewife **10b. KIND OF BUSINESS OR INDUSTRY** None **11. BIRTHPLACE** New York **12. CITIZEN OF WHAT COUNTRY?** U.S.A.

13. FATHER'S NAME Schul **14. MOTHER'S MAIDEN NAME** Unknown

15. WAS DECEASED EVER IN THE ARMED FORCES? No **16. INFORMANT** Unknown Address

18. CAUSE OF DEATH (Enter only one cause. If more than one, list them in order of importance.)
PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE Pneumonia & Cerebritis - Diabetes -
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (Enter in order of importance) Chronic nephritis & hypertension

19. INTERVIEW SET (Enter date of onset and death) 5/15/61
20. WAS A POSTMORTEM PERFORMED? YES ☐ NO ☒

20a. TIME OF INJURY (If applicable) 19 **20b. DESCRIBE HOW INJURY OCCURRED** None
20c. TIME OF INJURY (If applicable) 19 **20d. INJURY OR ILLNESS** None
20e. PLACE OF INJURY (If applicable) None

21. I certify that I (this hospital) attended the deceased from 1938 **to** May 15, 1961, that (I) (we) last saw the deceased alive on May 15, 1961 and that death occurred 6:30 PM from the causes and on the date stated above.

22a. SIGNATURE Frederic V. Beutler **22b. DATE SIGNED** May 17 '61
22c. PHYSICIAN'S NAME (Type) FREDERIC V. BEUTLER **22d. ADDRESS** 1014 Francis St - Balto 27-4nd

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial **23b. DATE THEREOF** May 17, 1961 **23c. NAME OF CEMETERY OR CREMATORY** North Penna Ave **23d. LOCATION** (City, town or county) Baltimore State Md

24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Tuckman, Sons **25a. REC'D BY REGISTRAR** May 17 '61 **25b. REGISTRAR'S SIGNATURE**





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05306

1. PLACE OF DEATH
 a. COUNTY

Baltimore

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if not a native resident)
 a. STATE b. COUNTY

Ma.

b. CITY OR TOWN (If out of corporate limits write RURAL and give nearest town)

Catonsville

c. LENGTH OF STAY IN

c. CITY OR TOWN (If out of corporate limits write RURAL and give nearest town)

Balto.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)

House In The Pines 16 Fusting Ave

d. STREET ADDRESS

4904 Alson Dr.

IS RESIDENCE ON A FARM?
 YES ☐ NO ☒

3. NAME OF DECEASED
 (Type or print)

Mary

T,

Pessagno

4. DATE OF DEATH

Month

Day

Year

May 28, 1961

5. SEX

6. COLOR OR RACE

7. MARRIED ☐ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (in years if UNDER 1 YEAR if UNDER 24 HRS.)

F.

W.

WIDOWED ☒ DIVORCED ☐

Sept. 2, 1873

87 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (Country & State)

12. CITIZEN OF WHAT COUNTRY?

H.W.

O.H.

Ma.

USA

13. FATHER'S NAME

Pessagno

14. MOTHER'S MAIDEN NAME

Rosa Paretti

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Miss Rose Pessagno, 4904 Alson Dr.

18. CAUSE OF DEATH (Enter only or code as per instructions)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. A. TIME OF INJURY (If EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of form 18)

20c. TIME OF INJURY (Hour, e.m., p.m.)

Month, Day, Year

20d. INJURY OCCURRED (While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town

County

State

21. I certify that (I) (this hospital) attended the deceased from 5:27, 1961, to 6:15 AM, 1961, that (I) (we) last saw the deceased alive on... 1961 and that death occurred at 6:15 AM, from the causes and on the date stated above.

22a. SIGNATURE

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
 M.D. 22d. ADDRESS

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town or county)

State

Burial

May 31 /61

New Cathedral Cmty.

Balto. Md.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

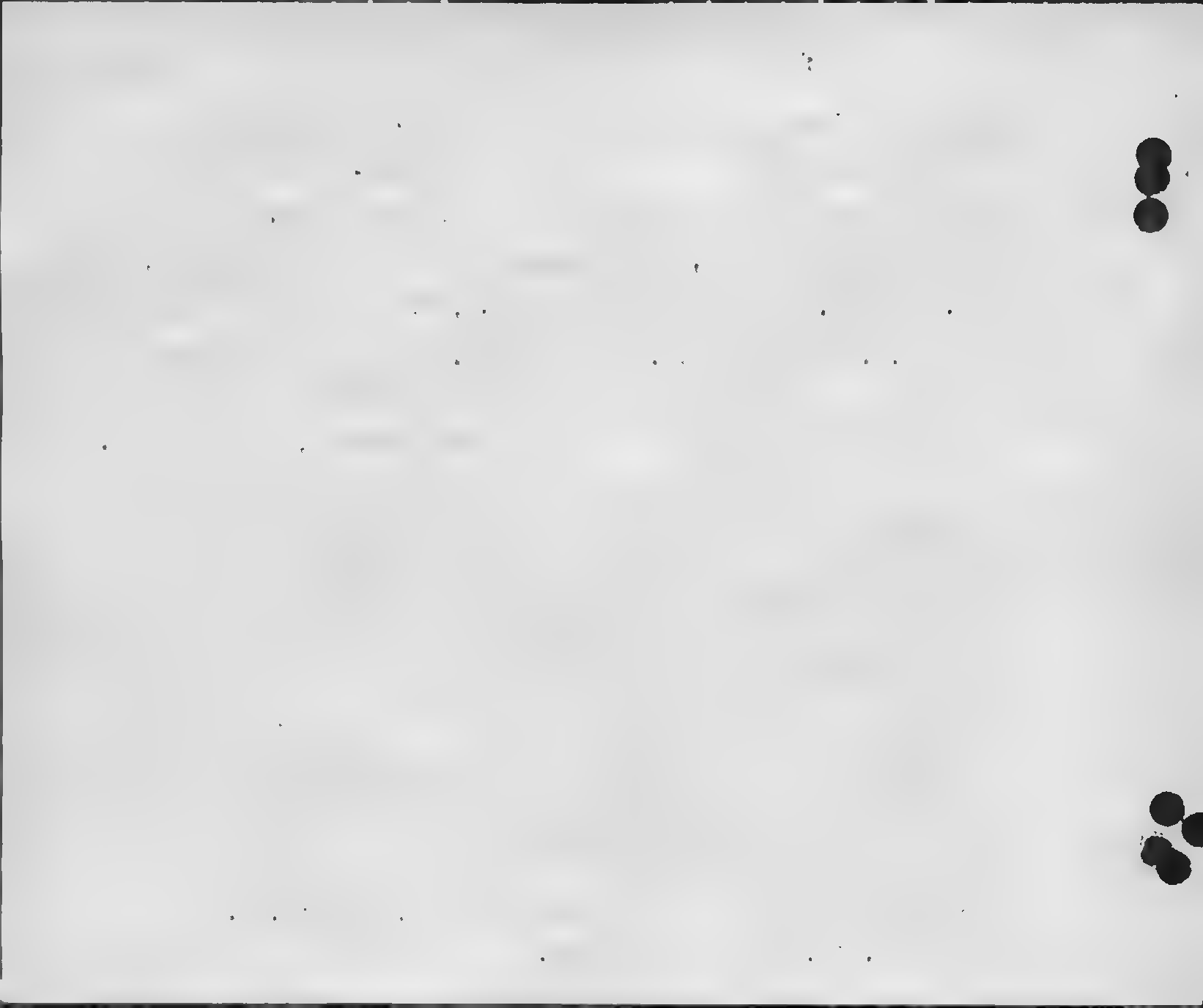
25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

Witzke Fun. Dir. 4101 Edmondson Ave.

DATE MAY 31 '61

TO HOUSING DEPARTMENT: The law requires that the death certificate be executed by a physician after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5315

05307

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Towson

c. LENGTH OF STAY IN 1b

1 month

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Towson Convalescent Home

2. USUAL RESIDENCE (Where deceased lived last 12 months or Residence before admission)

a. STATE

Maryland

b. COUNTY

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Baltimore

d. STREET ADDRESS

Hopkins Apartments

IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED
(Type in print)

First

Jane

Middle

Theresa

Last

Pillsbury

4. DATE OF DEATH

Month

May

Day

9

Year

19 61

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒ **8. DATE OF BIRTH**

WIDOWED ☐ DIVORCED ☐

June 29, 1870

9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 2 HRS.

90 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

School Teacher PUBLIC SCHOOLS.

10b. KIND OF BUSINESS OR INDUSTRY

High Seas (U.S. Vessel)

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Benjamin Pillsbury

14. MOTHER'S MAIDEN NAME

Jane Lamb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO. **17. INFORMANT**

DR. H. C. PILLSBURY 1800 N. CHARLES ST

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE

Arteriosclerotic Cardiovascular Disease

INTERVAL BETWEEN ONSET AND DEATH
5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of form 18)

20c. TIME OF INJURY
Hour a.m.
p.m.

Month, Day, Year
19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

County

(State)

21. I certify that (I) (physician) attended the deceased from March 1961, to May 9, 1961 that (I) (not) saw the deceased alive on May 7, 1961, and that death occurred at 2 P.M. from the causes and on the date stated above

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

William A. Pillsbury

M.D.

ATTENDING PHYS ☒

MED. DIRECTOR ☐

STAFF PHYS ☐

22d. ADDRESS

2060 York Road, Timonium, Maryland

22b. DATE SIGNED
May 10, 1961

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

5/13/61

23c. NAME OF CEMETERY OR CREMATORY

DRUID RIDGE

23d. LOCATION (City, town or county)

PIKESVILLE, MD

24. BURIAL DIRECTOR'S SIGNATURE

H.W. MEARS & SON 805 N. CALVERT ST.

25a. REC'D BY REGISTRAR

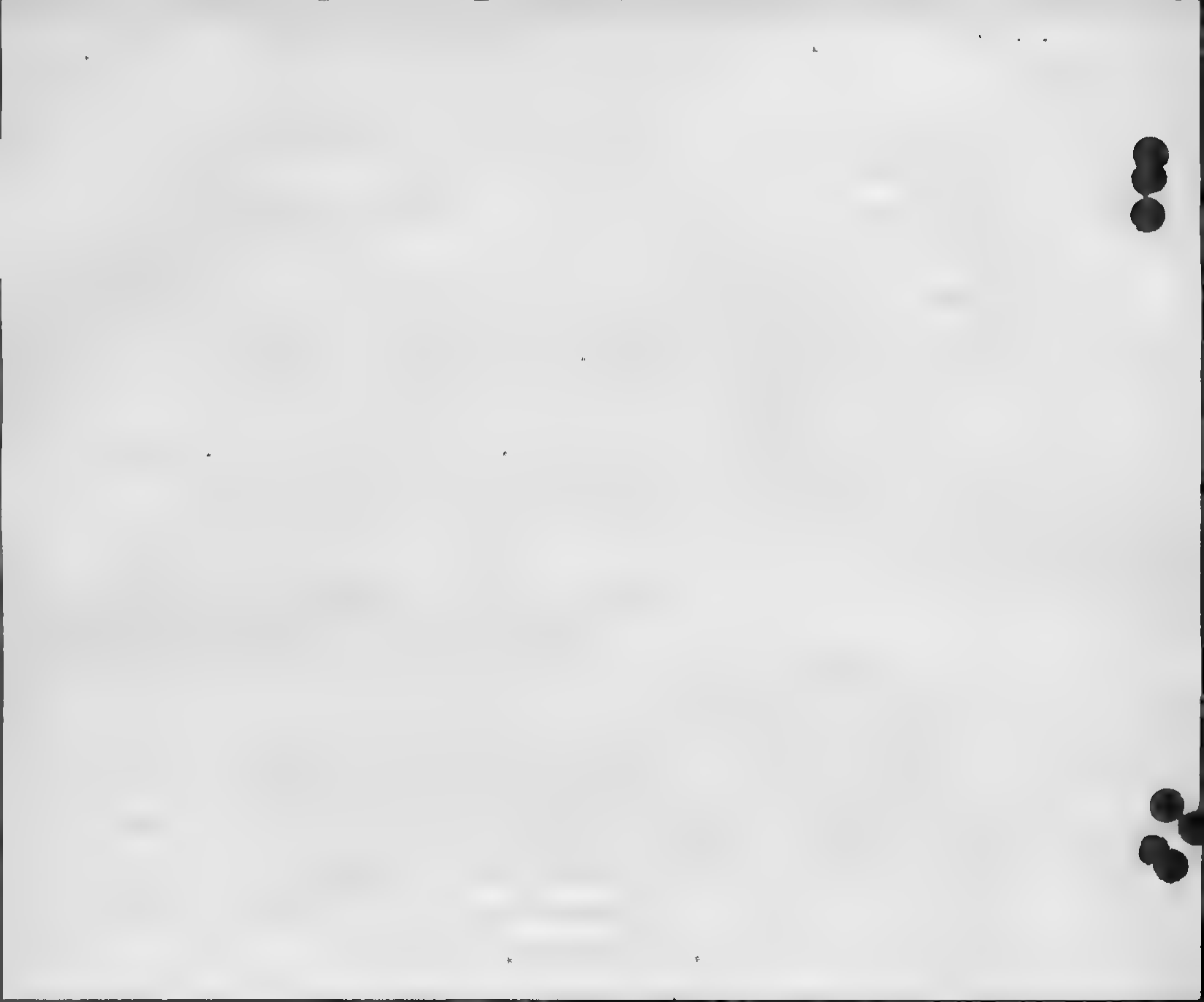
MAY 15 '61

25b. REGISTRAR'S SIGNATURE

Charles A. Jones

TO HO... ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, on any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5316

05308

1 PLACE OF DEATH a COUNTY <u>BALTIMORE</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUMMITT NURS. HOME</u>				d. STREET ADDRESS <u>835 WOODINGTON RD</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>SAMUEL</u> <u>PLAIKEY</u>				4 DATE OF DEATH Month Day Year <u>MAY</u> <u>28</u> <u>1961</u>			
5 SEX <u>M.</u>	6 COLOR OF RACE <u>W.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>JULY 20, 1896</u>		9 AGE (In years last birthday) <u>74</u> yrs	10 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED, AMERICAN SUGAR REFIN.</u>				10b KIND OF BUSINESS OR INDUSTRY <u>LITHUANIA</u>		11 BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13 FATHER'S NAME <u>PLAIKEY</u>				14 MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown) If yes, give war or dates of service.				16 SOCIAL SECURITY NO.		17 INFORMANT Address <u>MISS DIANNA TRAIKEY, 835 WOODINGTON RD.</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage Cerebral Hemisphere Right</u> DUE TO (b) <u>Arteriosclerosis Generalized</u> DUE TO (c) <u>Myocardial Infarction Recent</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour o m p m 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) <u>BALTO.</u>				20g (State) <u>MD</u>			
21 I certify that (I) (this hospital) attended the deceased from <u>5/27/61</u> to <u>5/28/61</u> , that (I) last saw the deceased alive on <u>5/27/61</u> , and that death occurred on <u>5/28/61</u> PM, from the causes and on the date stated above							
22a SIGNATURE <u>W. E. McGroth MD</u>				22b ADDRESS <u>1303 Frederick Rd (28)</u>		22c DATE SIGNED <u>5/30/61</u>	
22c PHYSICIAN'S NAME (Type) <u>W. E. McGroth MD</u>				22d ADDRESS <u>1303 Frederick Rd (28)</u>			
23a BURIAL CREMATION <u>BURIAL</u>				23b DATE THEREOF <u>JUNE 2/61</u>		23c NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>	
23d LOCATION (City town or county) <u>BALTO. MD.</u>				23e (State) <u>MD</u>			
24 FUNERAL DIRECTOR'S SIGNATURE <u>W. E. McGroth MD</u>				25a REC'D BY REGISTRAR <u>DATE MAY 31 '61</u>		25b REGISTRAR'S SIGNATURE	



1
FOR STATE
HEALTH DEPT.

M

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

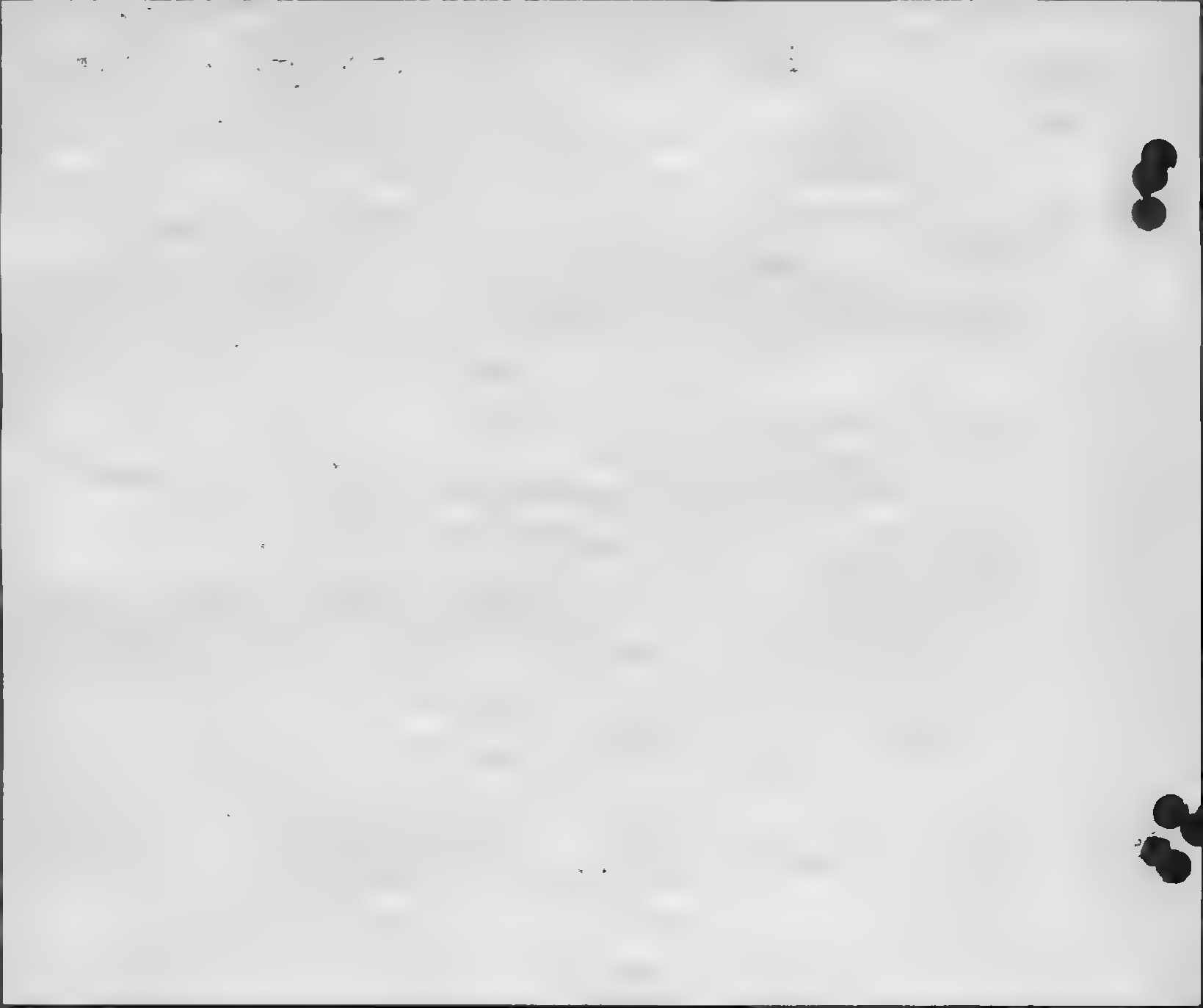
VS. A15ME
5M 9/60

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
217
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05309

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Record new residence) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8721 Baker		e. STREET ADDRESS 8721 Baker	
3. NAME OF DECEASED (Type or print) JAMES EDWARD PRICE		4. DATE OF DEATH Month May Day 12 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 31-1916
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) KALAR I-STER BONDIX		9. AGE (In years last birthday) 51 yrs. IF UNDER 1 YEAR: Months 1 Days 12 Hours 19 Min 61	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
13. FATHER'S NAME JAMES HENRY PRICE		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES-69-68-60		14. MOTHER'S MAIDEN NAME BIRDIE STANFILL	
16. SOCIAL SECURITY NO. 28-69-4830		17. INFORMANT Mrs. HATHEN PRICE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Thrombosis DUE TO (b) Arteriosclerotic Cardiovascular Disease. DUE TO (c) Arteriosclerotic Cardiovascular Disease. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 5-16-61	
22c. NAME OF CEMETERY OR CREMATORY DUNN CEMETERY		22d. LOCATION (City, town or country) (State)	
23. FUNERAL DIRECTOR James E. Hark		24a. REC'D BY REGISTRAR 5305 Harkford	
ADDRESS		24b. REGISTRAR'S SIGNATURE Charles S. Petty	

DATE SIGNED
5/13/61



5319

CERTIFICATE OF DEATH

Reg. Dist. No. 310

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 8-months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forleigh Nursing Home		d. STREET ADDRESS S. Rolling Road (28)	
3. NAME OF DECEASED (Type or print) KATHARINE KNAPP PURNELL		4. DATE OF DEATH May-17-1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct-19-1884
9. AGE (In years last birthday) 76 yrs		10. FUND 2 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME George W. Knapp		14. MOTHER'S MAIDEN NAME Katharine Boone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO none	
17. INFORMANT J. H. Purnell Jr. (son) Owings Mills, Balto. Co. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease			
4200 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary thrombosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 19, 1950 to May 17, 1961 , that I last saw the deceased alive on May 17, 1961 , and that death occurred at 11:35 P.M. from the causes and on the date stated above			
ADDRESS (Street, city or town, state) DATE SIGNED 5-17-61			
ACTUAL SIGNATURE Joseph D. Blasing		M.D. 1210 Antares Lane	
PHYSICIAN'S NAME (Type) JOSEPH D. BLASING, M.D.			
22a. BURIAL, CREMATION REMOVAL (Specify) burial	22b. DATE THEREOF May-20-61	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge	22d. LOCATION (City, town, or county) (State) Pikesville, Baltimore 8.
23. FUNERAL DIRECTOR'S SIGNATURE Stewart & Mowen Co. 108-W-North-Av., Balto-1, Md		24a. REC'D BY REGISTRAR MAY 18 '61 DATE	
		24b. REGISTRAR'S SIGNATURE W. S. Tuma	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be completed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, it is to be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05311

1. PLACE OF DEATH
a. COUNTY **Baltimore** b. CITY OR TOWN if outside corporate limits write RURAL and give nearest town **Fort Howard** c. LENGTH OF STAY IN 1b **33 Days** d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Veterans Administration Hospital**

2. USUAL RESIDENCE Where deceased lived, if outside of State, give State and County
a. STATE **Maryland** b. COUNTY **Baltimore** c. CITY OR TOWN if outside corporate limits write RURAL and give nearest town **2415 Woodbrook Avenue** d. STREET ADDRESS **2415 Woodbrook Avenue**

3. NAME OF DECEASED (Type or print) **CARL L. RAMOS** 4. DATE OF DEATH **MAY 13 19 61**

5. SEX **Male** 6. COLOR OR RACE **Brown** 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH **5/23/03** 9. AGE (in years, last birthday) **57 yrs** IF UNDER 1 YEAR: Months Days Hours Min. **57 yrs** IF UNDER 2 HRS: Months Days Hours Min. **57 yrs**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Mechanic** 10b. KIND OF BUSINESS OR INDUSTRY **Auto Service** 11. PLACE OF BIRTH **Hawaii** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Robert Ramos** 14. MOTHER'S MAIDEN NAME **Mary Ennie**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? **Yes** 16. SOCIAL SECURITY NO. **WW II** 17. INFORMANT **Clin. Rec. VAH, Balto. Md. Ft. Howard Division** Address **Clin. Rec. VAH, Balto. Md. Ft. Howard Division**

18. CAUSE OF DEATH (Enter on only one cause per line for a, b, and c)
PART I. DEATH WAS CAUSED BY:
a. IMMEDIATE CAUSE (a) **CARCINOMA OF THE PROSTATE WITH METASTASES TO PELVIC BONE**
b. **BILATERAL PYELONEPHRITIS**
c. **UNKNOWN**
DUE TO **UNKNOWN**

19. PART II. PREEXISTING AND CONTRIBUTING CONDITIONS CONTRIBUTING TO DEATH: (NOT RELATED TO THE TERMINAL DISEASE) (CONDITION GIVEN IN PART I)
a. **UNKNOWN**

20a. ACCIDENTAL OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter in Part I or Part II of item 18)
20c. TIME OF INJURY (Month, Day, Year) **April 10 1961** to **May 13 1961**
20d. INJURY OCCURRED (While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **11:40 AM**

21. I certify that (if this is a physician) attended the deceased from **April 10 1961** to **May 13 1961** that (if we) last saw the deceased live on **May 13, 1961** and that death occurred on **May 13, 1961** from the causes and on the date stated above.

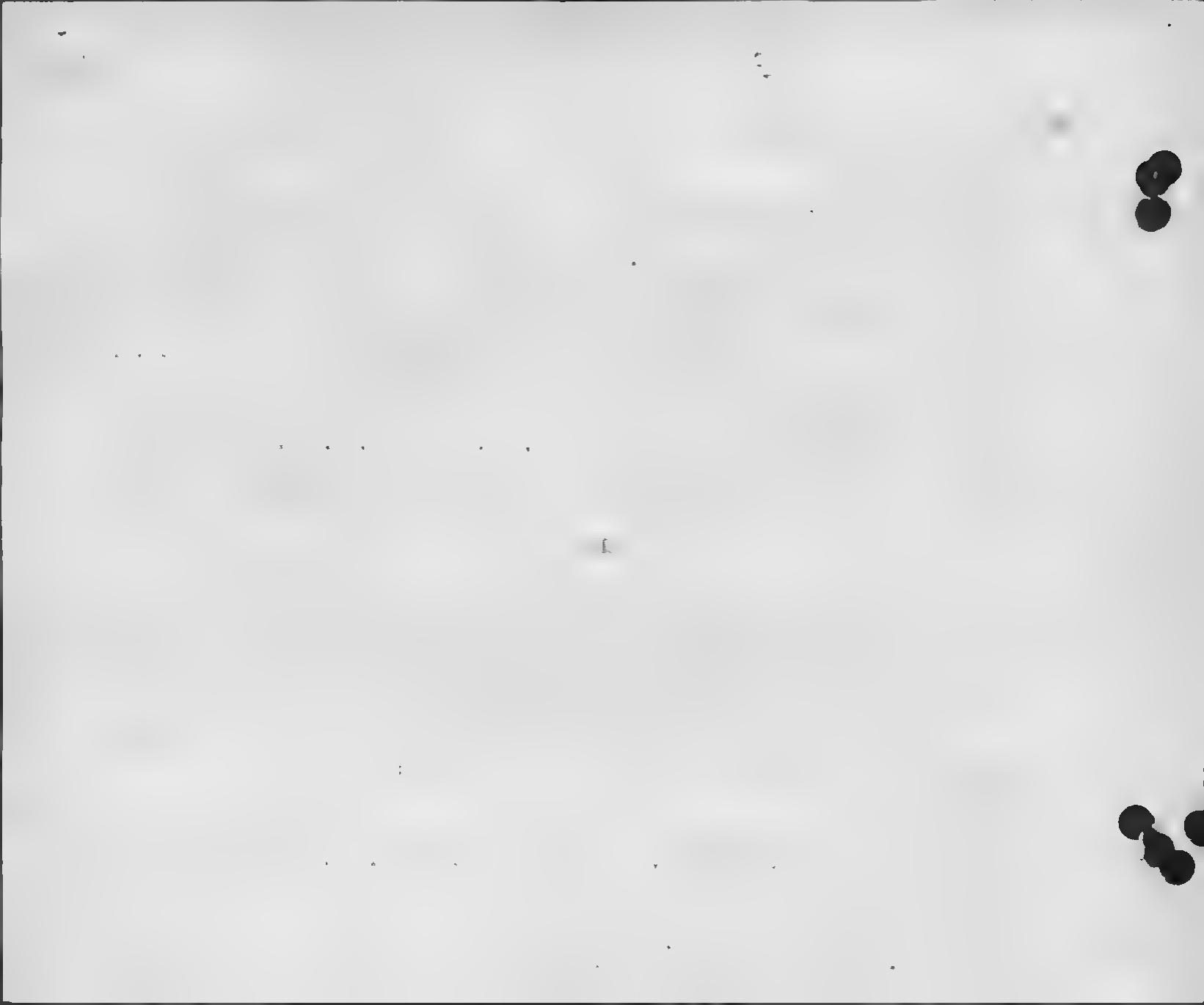
22. PHYSICIAN'S NAME (Type) **JACK C. LEWIS, M.D.** 22a. ADDRESS **VAH, BALTO. MD. FORT HOWARD DIVISION** 22b. DATE SIGNED **5/13/61**

23a. BURIAL CREMATION REMOVAL (Specify) **Burial** 23b. DATE INTERMENT **5-17-61** 23c. NAME OF CEMETERY OR CREMATORY **Fort Howard Division** 23d. LOCATION (City town or county) **BALTO. MD.**

24. FUNERAL DIRECTOR'S SIGNATURE **George G. Kelson** 24a. ADDRESS **1348 N. Calhoun Street Baltimore 17, Maryland** 25a. REC'D BY REGISTRAR **MAY 15 '61** 25b. REGISTRAR'S SIGNATURE

TO HO... OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

15312

5320

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a STATE Maryland b COUNTY Harford	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c LENGTH OF STAY IN TB 33yr5mth8dys	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e STREET ADDRESS unknown	
3 NAME OF DECEASED (Type or print) First Middle Last Joseph Rasetta		4. DATE OF DEATH Month Day Year May 14 19 61	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 6, 1888
9 AGE (In years last birthday) 73 yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) Italy
12 CITIZEN OF WHAT COUNTRY? Italy		13 FATHER'S NAME Pasqual Rasetta	
14 MOTHER'S MAIDEN NAME Rosalletta		15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown	
16 SOCIAL SECURITY NO. (If yes, give war or dates of service) unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o m p m 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1954, to May 14, 1961, that I last saw the deceased alive on May 14, 1961, and that death occurred at 2:45 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL 5-15-61	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a BURIAL CREMATION REMOVAL (Specify) Burial		22b DATE THEREOF 5/16/61	
22c NAME OF CEMETERY OR CREMATORY Cathedral		22d LOCATION (City, town, or county) (State) 4300 Old Federal	
23 FUNERAL DIRECTOR'S SIGNATURE J. J. Foley (Sons)		ADDRESS 1318 Light	
24a REC'D BY REGISTRAR		24b REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be filled out by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg Dist No. 05313

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>1yr11mth12dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>1907 Belmont Terrace</u>	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Henry</u> Last <u>Reals</u>		4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-21-86</u>
9. AGE (In years last birthday) <u>75</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>paint sprayer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Upholstering Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Little Falls, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George H. Reals</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>074-07-0923</u>	
17. INFORMANT <u>George W. Reals-1907</u> Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Terminal pulmonary thrombosis and infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old cerebral thrombosis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 25, 1961</u> , to <u>May 7, 1961</u> , that I last saw the deceased alive on <u>May 7, 1961</u> , and that death occurred at <u>9:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL 5-8-61</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		<u>Catonsville 28, Md.</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-10-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Lickner & Sons</u>		24a. REC'D BY REGISTRAR DATE <u>5-11-61</u>	
ADDRESS <u>1100 Pa Ave NW</u>		24b. REGISTRAR'S SIGNATURE <u>1-2-61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. This certificate may be returned to the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05314

1. PLACE OF DEATH
a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 3 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution) e. STATE Maryland f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 536 Oxford Street (1) e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) WILLIE REDDICK 4. DATE OF DEATH May 2 1961 5. SEX Male 6. COLOR OR RACE Colored 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH May 10, 1930 9. AGE IN YEARS (If UNDER 1 YEAR, last birthday; If UNDER 24 HRS, Months Days Hours Min) 72 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman 11. KIND OF BUSINESS OR INDUSTRY Hennison, North Carolina 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Will Reddick 14. MOTHER'S MAIDEN NAME Jerome MN: Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) Yes WW I 16. SOCIAL SECURITY NO. 213-18-9334 17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division 18. CAUSE OF DEATH (Enter only one cause per line for Part I. Death was caused by: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO SENILE EMPHYSEMA AND PULMONARY CARCINOMA b. UNKNOWN c. UNKNOWN PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Arteriosclerotic Cardiovascular Disease 19. WAS A "POPSY" PERFORMED? YES ☐ NO ☒

20a. TIME OF INJURY (Hour a.m. p.m.) 19 20b. INJURY OCCURRED (While at work ☐ Not While at work ☐ 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH, BALTO. 18, MD., FT. HOWARD DIVISION 20d. (City or town) Baltimore (County) Maryland (State) Maryland

21. I certify that (X) (this hospital) attended the deceased from April 4 1961 to May 2 1961 that (X) (we) last saw the deceased alive on May 2 1961, and that death occurred at 3:30 P.M. from the causes and on the date stated above

22a. SIGNATURE Thomas F. Crahan 22b. DATE SIGNED 5/2/61 22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D. 22d. ADDRESS VAH, BALTO. 18, MD., FT. HOWARD DIVISION

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5/5/61 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. 23d. LOCATION (City, town or county) Baltimore (State) Maryland

24. FUNERAL DIRECTOR'S SIGNATURE Adolphus Halstead 25a. REC'D BY REG. STRAR 918 Dr. J. H. Hall Ave 25b. REGISTRAR'S SIGNATURE DATE MAY 4 '61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4,
15M 9/58

Page 4

I

(M)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5323

CERTIFICATE OF DEATH

Reg. Dist. No. 05315

1 PLACE OF DEATH a COUNTY <u>Balto</u> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u> c LENGTH OF STAY IN TB d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>8211 Shore Rd</u>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <u>md</u> b COUNTY <u>Balto</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u> d STREET ADDRESS <u>8211 Shore Rd</u> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3 NAME OF DECEASED (Type or print) First <u>NANCY</u> Middle <u>RENTSCHLER</u> Last <u>RENTSCHLER</u> 4 DATE OF DEATH Month <u>MAY</u> Day <u>19</u> Year <u>1961</u>		5 SEX <u>Female</u> 6 COLOR OR RACE <u>White</u> 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8 DATE OF BIRTH <u>Aug 6 - 1953</u> 9 AGE (In years lost birthday) yrs. <u>7</u> 10 IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> 11 IF UNDER 24 HRS Hours <u>7</u> Min <u>7</u>		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> 10b KIND OF BUSINESS OR INDUSTRY <u>—</u> 11 BIRTHPLACE (State or foreign country) <u>Balto Md.</u> 12 CITIZEN OF WHAT COUNTRY?		13 FATHER'S NAME <u>Cesar Rentschler Jr</u> 14 MOTHER'S MAIDEN NAME <u>Mary Lannon</u>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give year or dates of service) 16 SOC. SEC. NO. <u>Parents (same as above)</u>		INFORMANT Address <u>Parents (same as above)</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hematoma</u> DUE TO (b) <u>Fracture skull</u> DUE TO (c) <u>—</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19 WAS A TISSUE PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> <u>Congenital brain aneurysm - Composite</u>				
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Injury (15 lbs) fell from bed</u> 20c TIME OF INJURY Month <u>5</u> Day <u>9</u> Year <u>1961</u> 20d INJURY OCCURRED (a) <u>While at work</u> (b) <u>Not while at work</u> 20e PLACE OF INJURY (Home, farm, factory, street, office, blog, etc.) <u>Home</u> 20f CITY OR TOWN (State) <u>Balto Md.</u>				
21. I certify that I attended the deceased from <u>8-19</u> , 19 <u>53</u> , to <u>5-19</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>5-17</u> , 19 <u>61</u> , and that death occurred at <u>1 P.M.</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>L. Bruce L. Jones</u> M.D. ADDRESS (Street, city or town, state) <u>1942 Cedar Lane</u> DATE SIGNED <u>Balto Md 7/24</u>				
22a BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u> 22b DATE THEREOF <u>May 23-1961</u> 22c NAME OF CEMETERY OR CREMATORY <u>U.S. Balt. Natl. Cem.</u> 22d LOCATION (City, town or county) (State) <u>Balto Md</u>				
23 FUNERAL DIRECTOR'S SIGNATURE <u>Am. S. Connolly</u> ADDRESS <u>418 Eastern Blvd.</u> 24a REC'D BY REGISTRAR DATE <u>MAY 24 '61</u> 24b REGISTRAR'S SIGNATURE <u>L. Bruce L. Jones</u>				



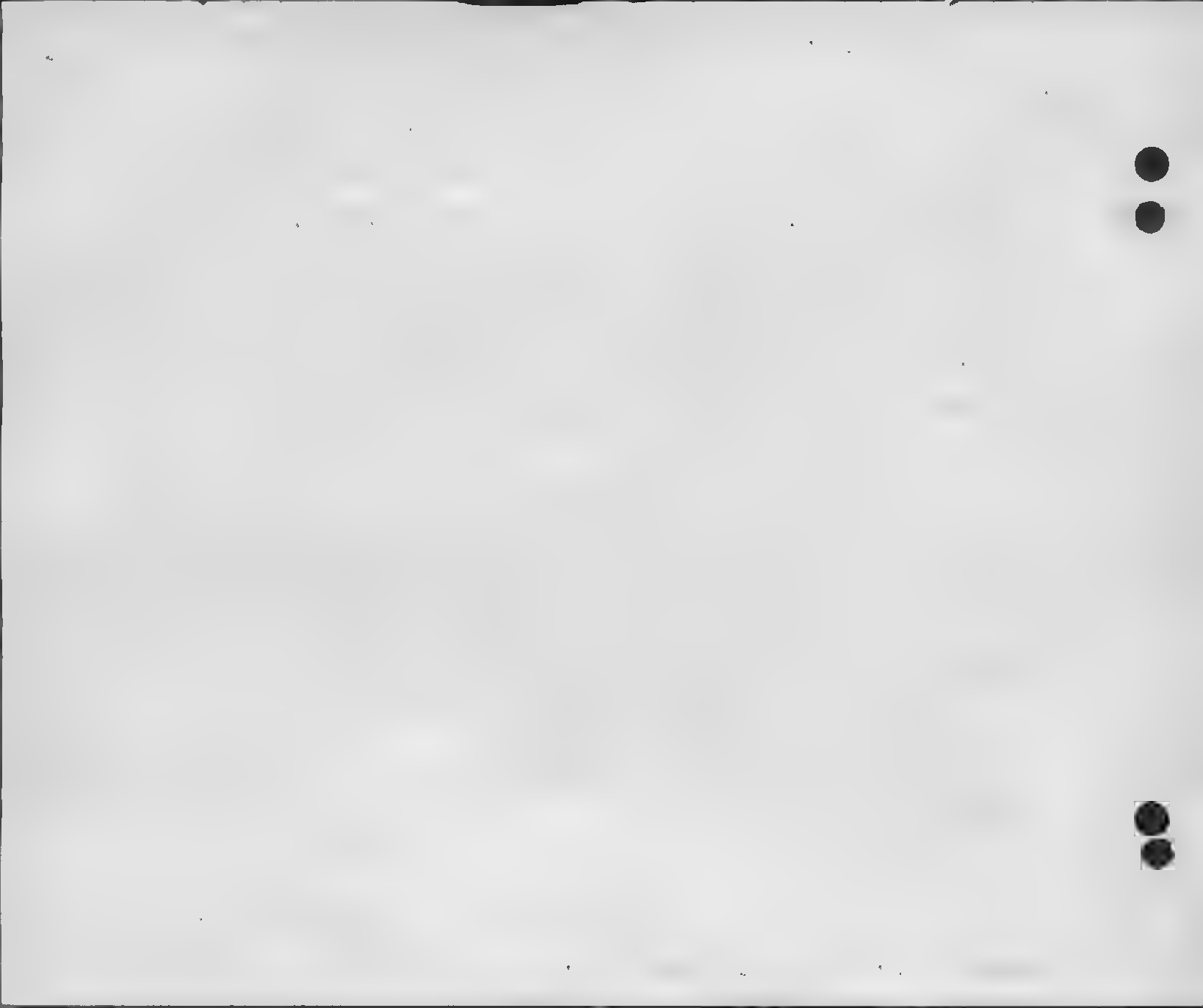
1
Page 4
The law requires that the death certificate be executed within 24 hours after death.
The attending physician, the hospital or attending physician, or the funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

324
MAY 26 1961
15316
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived first full year before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>	
c. LENGTH OF STAY IN 1b <u>2 yrs. 3 mos.</u>		d. STREET ADDRESS <u>none</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood Training School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Sylvia Delores Richardson</u>		4 DATE OF DEATH Month <u>5</u> Day <u>22</u> Year <u>19 61</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5/20/58</u>
9 AGE (in years lost birthday) <u>3</u> yrs.		10 UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul Edward Richardson</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Kathleen Graham, Chester, Md.</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Rosewood Records</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition</u> DUE TO <u>Arnold Chiari Syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u>none</u> DUE TO (c) <u>none</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>since birth</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
19 WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that () (th) (his) (her) (hospital) attended the deceased from <u>5/20/58</u> , 19 <u>61</u> to <u>5/21/61</u> , 19 <u>61</u> that (I) (we) (us) saw the deceased alive on <u>5/21/61</u> , 19 <u>61</u> and that death occurred at <u>9 a.m.</u> from the causes and on the date stated above			
22a SIGNATURE <u>Harry G. Butler</u>		22b DATE SIGNED <u>5/26/61</u>	
22c PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u>		22d. ADDRESS <u>Rosewood Lane, Owings Mills, Md.</u>	
23a B. I. P. A. CREMATION REMOVAL <u>Spontaneous</u>		23b DATE THEREOF <u>May 26, 61</u>	
23c NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		23d LOCATION (City, town or county, state) <u>St. John's, Queen Anne's Co., Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>John J. Smith</u>		ADDRESS <u>1111 N. ...</u>	
25a REC'D BY REGISTRAR <u>John J. Smith</u>		25b REGISTRAR'S SIGNATURE <u>John J. Smith</u>	
DATE <u>5/26/61</u>		TIME <u>1:18 p.m.</u>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05318

5326

1. PLACE OF DEATH a. COUNTY <u>27</u> <u>Md.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>0-11a</u> <u>Catonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>0-11a</u> <u>Catonville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>315 0-11a Ave</u>		d. STREET ADDRESS <u>1 315 0-11a Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Ridout</u> Last <u>Ridout</u>		4. DATE OF DEATH Month <u>May</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-1910</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cardner</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>George Ridout</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-28-9431</u>	
17. INFORMANT <u>Robert Ridout</u> Address <u>315 0-11a Ave</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Arthritis</u>		CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Robert Ridout</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5-15-61</u>	<u>National Cem</u>	<u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Thomas</u> ADDRESS <u>1100 ...</u>		24a. REC'D BY REGISTRAR <u>MAY 10 1961</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay, please execute it as soon as possible, attaching the word "pending" in item 18. Give Page 1, 2, and 3 to the funeral home. Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

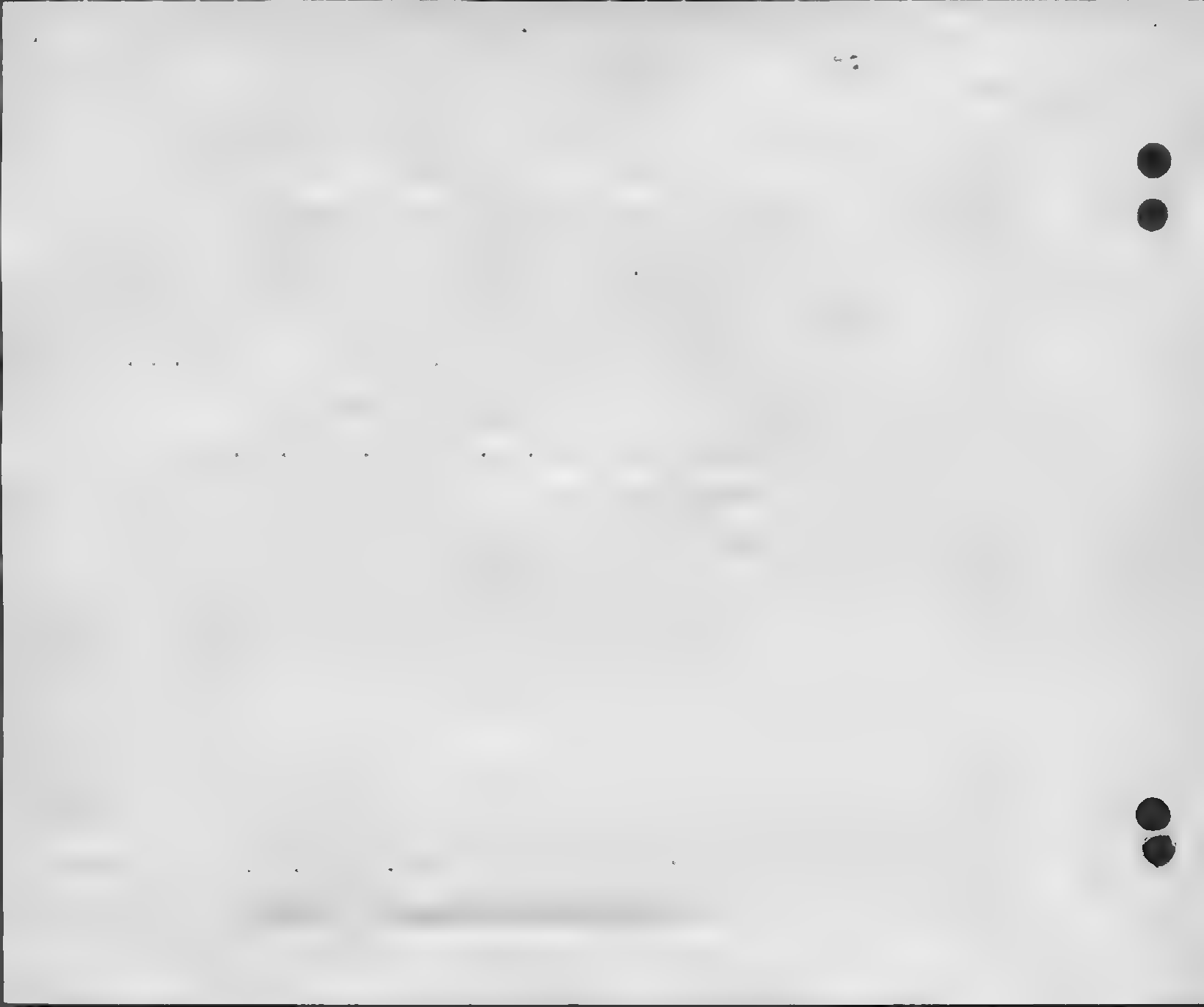
5327

05910

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harveys Mill</u> c LENGTH OF STAY IN 1b <u>2609 Elsinor Ave</u> d NAME OF HOSPITAL (If not in hosp to give street address) OR INSTITUTION <u>High Nursing Home</u>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <u>Md</u> b COUNTY _____ c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d STREET ADDRESS _____ e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>HELIHAN</u> 5 SEX <u>Female</u> 6 COLOR OR RACE <u>White</u> 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8 DATE OF BIRTH <u>8-29-1905</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9 AGE (in years last birthday) <u>55</u> yrs 10a USUAL OCCUPATION (Give kind of work done, even if retired) <u>Editor</u> 10b KIND OF BUSINESS OR INDUSTRY <u>News Paper</u> 11 BIRTHPLACE (State or foreign country) <u>New York</u> 12 CITIZEN OF WH. COUNTRY? <u>USA</u>		4. DATE OF DEATH Month <u>5</u> Day <u>3</u> Year <u>1961</u> IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
13 FATHER'S NAME <u>Samuel Wisner</u> 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) _____ 16 SOCIAL SECURITY NO _____		14 MOTHER'S MAIDEN NAME <u>Fisher Cooperman</u> 17 INFORMANT <u>Harvey Rivkin - Same</u> Address _____	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastasis to Brain of Carcinoma</u> (b) _____ of _____ gland (c) <u>Hemiparesis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BUT NOT TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>operated on for Carcinoma of Parotid gland 5/5/59</u> 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____ 20c TIME OF INJURY Month _____ Day _____ Year _____ 19 _____ 20d INJURY OCCURRED _____ Hour a. m. _____ p. m. _____ While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f (City or town) _____ (County) _____ (State) _____			
21 I certify that () (this hospital) attended the deceased from <u>5/14</u> 19 <u>57</u> to <u>5/3</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>5/3</u> 19 <u>61</u> and that death occurred at <u>7</u> M. from the causes and on the date stated above 22a SIGNATURE <u>[Signature]</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b ADDRESS <u>2320 Eutan Pl</u> 22c PHYSICIAN'S NAME (Type) _____			
23a BURIAL REMOVAL (Specify) <u>Funeral</u> 23b DATE THEREOF <u>5-6-61</u> 23c NAME OF CEMETERY OR CREMATORY <u>Israel</u> 23d LOCATION (City, town or county, etc.) <u>Baltimore</u> 24 FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>2100 Eutan Place</u> 25a REC'D BY REGISTRAR <u>[Signature]</u> 25b REGISTRAR'S SIGNATURE _____ DATE <u>5-6-61</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The attending physician, the hospital or attending physician, or the funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.





TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5229
05321
CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If rural, give corporate limit, write RURAL and give nearest town) Fort Howard 44 Days
c. LENGTH OF STAY IN IL
2 USUAL RESIDENCE Where dec. died lived, if institution, R
a. STATE Maryland b. COUNTY
c. CITY OR TOWN (If rural, give corporate limit, write RURAL)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give address) Veterans Administration Hospital 1631 Eutaw Place
3 NAME OF DECEASED (Type or print) First Middle Last 4 DATE OF DEATH Month Day Year
JAMES S. ROCK May 4, 1961
5 SEX MALE 6 COLOR OR RACE Colored 7. MARRIED [] NEVER MARRIED [] 8 DATE OF BIRTH March 2, 1920
9 AGE (If years, last birthday, Months, Days, Hrs, M)
10a US. A. OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10b KIND OF BUSINESS OR INDUSTRY Automobile Dealer 11 PLACE OF BIRTH Lancaster Co., Virginia U.S.A.
13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME

I
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) John R. Rock
16 SOCIAL SECURITY NO. 218-07-0259
17. INFORMANT Address Alverta G. Rice

Yes
18 CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE
BRONCHOGENIC CARCINOMA, RIGHT LUNG UNKNOWN
METASTATIC CARCINOMA, CHEST WALL UNKNOWN
CHRONIC CHOLECYSTITIS WITH CHOLELITHIASES UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I)
19. W. S. S. D. P. S. Y. PERFORMED? YES [] NO []

MEDICAL CERTIFICATION
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of form 12)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 20d. INJURY OCCURRED While at work [] Not While at work [] 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. City or town County State

21. I certify that (this hospital) attended the deceased from March 21, 1961, to May 4, 1961, that (we) last saw the deceased alive on May 4, 1961 and that death occurred at 4 PM, from the causes and on the date stated above.

22a SIGNATURE
22b. DATE SIGNED 5/5/61
22c. PHYSICIAN'S NAME (Type) M.D. ATTENDING PHYS [] MED. DIRECTOR [] STAFF PHYS []
THOMAS F. CRAHAN, M.D. 22d ADDRESS VAH, BALTO. 18, MD., FORT HOWARD DIVISION

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b DATE THEREOF 5-9-61 23c NAME OF CEMETERY OR CREMATORY Arlington S. Phillips 23d LOCATION City, town or county Baltimore Maryland
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a REC'D BY REG. STRAR 25b REGISTRAR'S SIGNATURE

VR A15 (4)
15M 9:60
Arlington S. Phillips 1800 N. Monroe St. Balto 17, Md. MAY 10 1961



CERTIFICATE OF DEATH

Reg. Dist. No.

05322

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a STATE <u>Indiana</u> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> 4		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Evansville</u>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1735 York Road</u>		d STREET ADDRESS <u>414 Chestnut Ave</u>	
3 NAME OF DECEASED (Type or print) First <u>Diana D.</u> Middle <u>Lily</u> Last <u>Weeks</u>		4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1961</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-28-01</u>
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing</u>		9b AGE (in years last birthday) <u>60</u> yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Ind</u>	
11 BIRTHPLACE (State or foreign country) <u>Ind</u>		12 CITIZEN OF WHAT COUNTRY <u>Ind</u>	
13. FATHER'S NAME <u>Harry Tomey</u>		14. MOTHER'S MAIDEN NAME <u>Lanie Ann Weeks</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO <u>309-36-5283</u>	
17 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO Cand trans, if any which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Coronary arteriosclerosis</u> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>	
18a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 12, 1961</u> to <u>May 12, 1961</u> , that I last saw the deceased alive on <u>May 12, 1961</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>R. Donald Cook</u> M.D.		DATE SIGNED <u>May 16, 1961</u>	
PHYSICIAN'S NAME (Type) <u>R. Donald Cook</u>		ADDRESS (Street, city or town, state) <u>1735 York Road, Towson, Md.</u>	
22a BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b DATE THEREOF <u>5-15-61</u>	
22c NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		22d LOCATION (City, town or county) (State) <u>Evansville, Indiana</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson, Inc., 1050 York Road, Towson 4</u>		24a REC'D BY REGISTRAR <u>May 16 '61</u>	
24b REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>		DATE <u>MAY 16 '61</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



HOSPITAL/CLINIC ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The Hospital or attending physician may be the attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral home. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral home. The State Board of Health prior to burial, cremation, or removal, and in any event within 48 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH**

11323

1. PLACE OF DEATH a. COUNTY BALTO		2. USUAL RESIDENCE (Where deceased lived if not at or Residence if admission to STATE b. COUNTY MARYLAND	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits write RLRA, and give nearest town) 329 HARLEM LANE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CATON RIDGE NURSING HOME		d. STREET ADDRESS 329 HARLEM LANE	
3. NAME OF DECEASED (Type or print) First Middle Last MARIA RUFFINI		4. DATE OF DEATH Month Day Year 5 19 1961	
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1888
9. AGE (In years last birthday) 72 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. BIRTHPLACE (State or foreign country) ITALY	12. CITIZEN OF WHEN 1
13. FATHER'S NAME VINCENT FALONE		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. CATON RIDGE HOME	
17. INFORMANT 329 HARLEM LANE		Address 329 HARLEM LANE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Collecting to Involence DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause (b) Diarrhea & Bile dection DUE TO Cause (c) Colitis INTERVAL BETWEEN ONSET AND DEATH 36 hrs 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. CITY OR TOWN (County, State)
21. I certify that (I) (this hospital) attended the deceased from Dec 1958 to May 19, 1961 . That (I) (we) last saw the deceased alive on May 19, 1961 , and that death occurred at 6 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Cliff Ratliff Jr.		22b. DATE 5/19/61	
22c. PHYSICIAN'S NAME (Type) CLIFF RATLIFF JR.		22d. ADDRESS 4605 EDMONDSON AVE #29	
23a. BURIAL CREMATION REMOVAL Sp. fr.	23b. DATE THEREOF 5/22/61	23c. NAME OF CEMETERY OR CREMATORY NAT. ERIN Cem.	23d. LOCATION (City, town, or county) (State) HARPER DE GRACE MD.
24. FUNERAL DIRECTOR'S SIGNATURE L. J. Ruck		25a. REC'D BY REGISTRAR 5305 HARFORD RD.	
25b. REGISTRAR'S SIGNATURE		DATE MAY 23 1961	



CERTIFICATE OF DEATH

Reg. Dist. No.

05324

1 PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		d. STREET ADDRESS 1631 Natura Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3 NAME OF DECEASED (Type or print) Melvin Ambrose Ruth		4. DATE OF DEATH Month May		Day 2-3		Year 1961		5 SEX Male		6 CO. OR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Jan. 17, 1908		9 AGE (In years last birthday) 53 yrs		F UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glenn L. Martin		10b KIND OF BUSINESS OR INDUSTRY Aircraft		11 BIRTHPLACE (State or foreign country) Highfield, Maryland		12 CITIZEN OF WHAT COUNTRY?		13 FATHER'S NAME Harvey A. Ruth		14 MOTHER'S MAIDEN NAME Unknown		15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-07-7006		17 INFORMANT Mrs. Mabel B. Ruth-1631 Natura Road Balto, Md.		Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Shock - Gastric Distension (c) Gastrointestinal Hemorrhage Hyperglycemia		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)					
21. I certify that I attended the deceased from Jan. 15, 1961 to May 15, 1961, and that death occurred at 12:30 A.M. from the causes and on the date stated above		22a BIRTHAL, CREMATION, REMOVAL (Specify) Burial		22b DATE THEREOF 5-25-61		22c NAME OF CEMETERY OR CREMATORY Greenhill Cemetery		22d LOCATION (City, town or county) (State)		23 FUNERAL DIRECTOR'S SIGNATURE H. J. Jackson, Jr.		24a REC'D BY REGISTRAR DATE MAY 24 '61		24b REGISTRAR'S SIGNATURE							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05325

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 5321 Maple Avenue	
3. NAME OF DECEASED (Type or print) or Harry Ryan		4. DATE OF DEATH Month May Day 17 Year 19 61	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1877
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR, IF UNDER 2, HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) plasterer		10b. KIND OF BUSINESS OR INDUSTRY construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William H. Ryan		14. MOTHER'S MAIDEN NAME Ellen Catken	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) unknown		16. SOCIAL SECURITY NO. 219-01-4881	
17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter on only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema			
(b) Terminal bronchopneumonia			
(c) Arteriosclerotic cardiovascular disease			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 13, 1961, to May 17, 1961, that I last saw the deceased alive on May 17, 1961, and that death occurred at 12:30 P. M. from the causes and on the date stated above			
ACTUAL SIGNATURE Stella Wachsler		DATE SIGNED ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL 5-17-61	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 26, Maryland	
22a. BURIAL, CREMATION REMOVAL (Specify) 5-17-61		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Union Park Cemetery		22d. LOCATION (City, town or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Schenck		24a. REC'D BY REGISTRAR DATE MAY 18 '61	
24b. REGISTRAR'S SIGNATURE C. S. S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained from the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HO... ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05326

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, first location) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Fort Howard</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Baltimore 17</u>	
d. NAME OF HOSPITAL OR INSTITUTION, if not in hospital give street address <u>Veterans Administration Hospital</u>		d. STREET ADDRESS <u>182 McCulloh</u>	
3. NAME OF DECEASED (Type or print) <u>SILAS</u>		4. DATE OF DEATH <u>May 12 1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 15, 1893</u>	
9. AGE (In yrs last birthday) <u>68</u>		10. FUNDING YEAR <u>12</u> IF FUNDING YEAR <u>1961</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas & Electric Co. West Moulton, Va.</u>	
11. BIRTHPLACE <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Samuels</u>		14. MOTHER'S MAIDEN NAME <u>Mildred -Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown, if yes give war or date of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>212-05-6153</u>	
17. INFORMANT <u>Clinical Records, VAH Baltimore 18</u>		18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE <u>CARDIAC ASYSTOLE</u> DUE TO <u>MYOCARDIAL INFARCTION</u> <u>EXX EXX EXX EXX OF PROSTATE WITH BONEY METASTASIS</u> PART II: OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITIONS ENTERED IN PART I) <u>CARCINOMA OF PROSTATE WITH BONEY METASTASIS</u>	
19. W. A. COPY PERFORMED? <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury, place, time, etc.)	
20c. TIME OF INJURY (Month, Day, Year) <u>April 27 1961</u>		20d. INJURY OCCURRED (While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>VAH Baltimore, Maryland</u>		20f. CITY OR TOWN <u>Fort Howard Division</u>	
21. I certify that (this hospital) attended the deceased from <u>April 27 1961</u> to <u>May 12 1961</u> (we) last saw the deceased alive on <u>May 12 1961</u> and that death occurred at <u>P.M.</u> from the causes and/or the date listed above.			
22a. SIGNATURE <u>JACK C. LEWIS</u>		22b. DATE <u>5-13-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JACK C. LEWIS</u>		22d. ADDRESS <u>VAH Baltimore, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>16 May 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City, town, county, State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLAND FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>May 16 1961</u>	
25b. REGISTRAR'S SIGNATURE <u>Holland</u>		25c. DATE <u>May 16 1961</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 1

327

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore			
b. CITY OR TOWN (If outside of corporate limits, write R.U.R.A. and give nearest town) Arbutus				c. LENGTH OF STAY IN 1b 17			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1311				d. STREET ADDRESS 1311			
3. NAME OF DECEASED (Type or print) First Juress Middle William Last Schanken				4. DATE OF DEATH Month May Day 11 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 14 1915	
9. AGE (in years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months 1 Days 14 Hours 14 Min.		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner & Operator of Gas & Oil Station				10b. KIND OF BUSINESS OR INDUSTRY Gas & Oil Station			
13. FATHER'S NAME Harry Schanken				14. MOTHER'S MAIDEN NAME Katherine Keefer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 216-69-5138		17. INFORMANT Kenneth E. Schanken		Address 1811	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Cardio Vascular heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE J. H. Hubbard				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 5/15/61		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				ADDRESS 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR DATE MAY 1 1961	
				24b. REGISTRAR'S SIGNATURE Robert J. [Signature]			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose it with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal to FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY **BALTO.** MARYLAND
b. CITY OR TOWN **ROSEDALE**
c. LENGTH OF STAY IN IT
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)
7317 HEINLE AVE.

2. USUAL RESIDENCE Where deceased lived 1. establishment 2. place
a. STATE **MD.** b. COUNTY **BALTO.**
c. CITY OR TOWN **ROSEDALE**
d. STREET ADDRESS **7317 HEINLE AVE.**

3. NAME OF DECEASED (Type or print)
WILLIAM SCHEELER

4. DATE OF DEATH **MAY 27 1961**

5. SEX **M** 6. COLOR OR RACE **W** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **4-15-1893** 68 yrs
9. AGE (in years) If under 1 year If under 1 year If under 24 hrs
last birthday Months Days Hours Min

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SHEET-METAL FOREMAN

11. BIRTHPLACE Country & State
MARYLAND

12. BIRTHPLACE Country
U.S.A.

13. FATHER'S NAME **FREDERICK SCHEELER** 14. MOTHER'S MAIDEN NAME **BERTHA HEIN**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If so, give or delete service)
NO

16. SOCIAL SECURITY NO. **214-03-2834** 17. INFORMANT **MRS. ADELE B. SCHEELER** Address **ABOVE**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **arteriosclerotic Heart Disease**
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (b) DUE TO (c) DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.
19. Was AUTOPSY PERFORMED? YES ☐ NO ☒

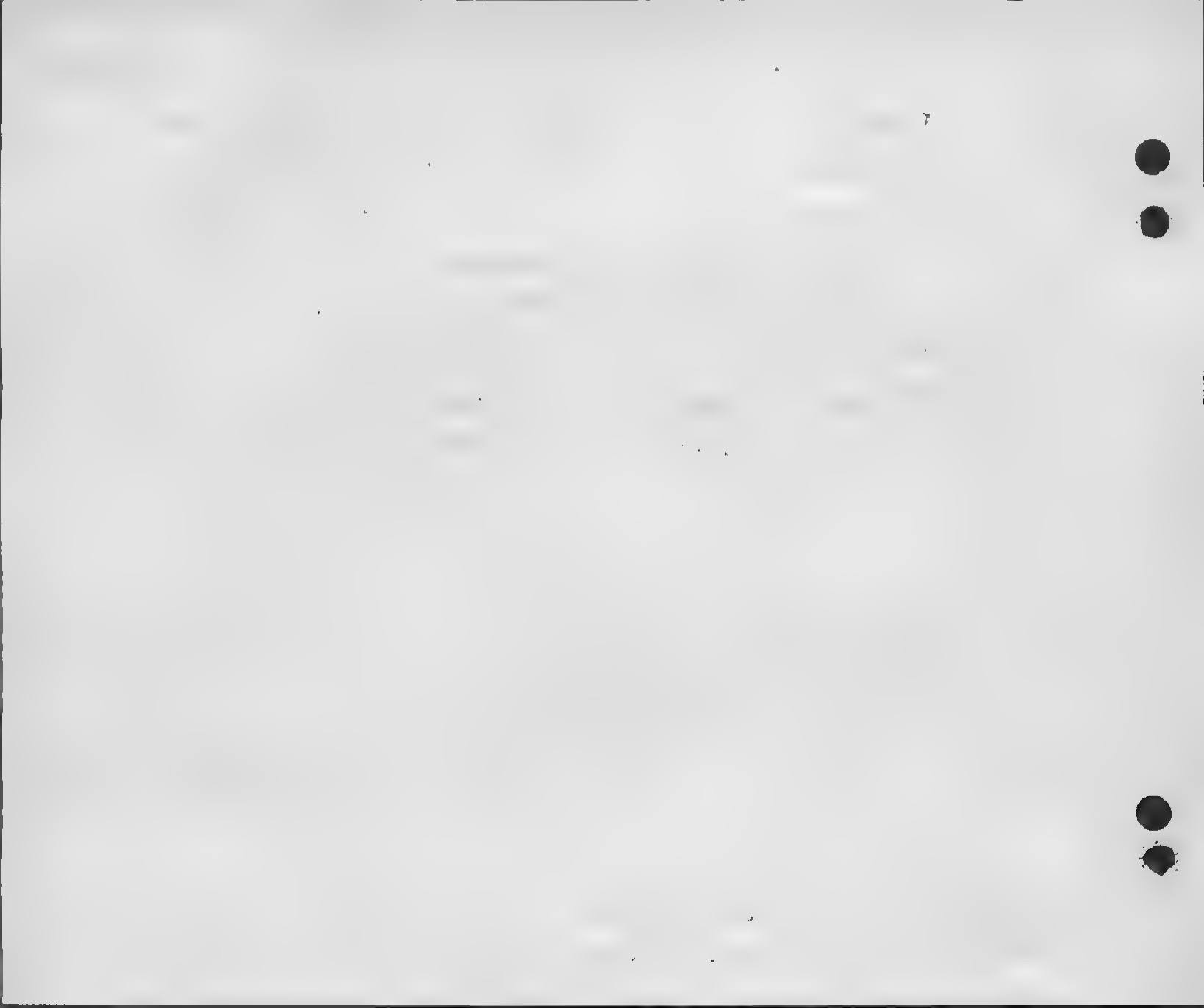
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of form 13)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. City or town 20g. County 20h. State

21. I certify that (I) (this hospital) attended the deceased from **May 22** to **May 27, 1961** that (I) (we) last saw the deceased alive on **May 22** 1961, and that death occurred at **7:27 P.M.** from the causes and on the date stated above.

22a. SIGNATURE **George Sawyer** 22b. DATE SIGNED **MAY 27 1961**
22c. PHYSICIAN'S NAME (Type) **GEORGE SAWYER M.D.** 22d. ADDRESS **411 E. FAIRFAX**

23a. BURIAL, CREMATION, REMOVAL Specify **BURIAL** 23b. DATE THEREOF **5-31-61** 23c. NAME OF CEMETERY OR CREMATORY **OAKLAND** 23d. LOCATION (City, town or county) **BALTO. Co.** State **MD.**

24. FUNERAL DIRECTOR'S SIGNATURE **H.W. JENKINS & SONS Co.** ADDRESS **4905 YORK ROAD** 25a. REC'D BY REGISTRAR **MAY 31 '61** 25b. REGISTRAR'S SIGNATURE **Arthur L. Kraus**



CERTIFICATE OF DEATH

Reg. Dist. No. 5329

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>7</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. LENGTH OF STAY IN 1b <u>5 1/2 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beltsville Nursing Home</u>		d. STREET ADDRESS <u>3636 Beltsville Av</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth M. Schwalbe</u>		4. DATE OF DEATH Month Day Year <u>May 19 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1887</u>
9. AGE (In years last birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Alcoholic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Frank A. Morgan</u>		14. MOTHER'S MAIDEN NAME <u>Marie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>111-111111</u>	
17. INFORMANT <u>Henry A. Schwalbe</u>		Address <u>Beltsville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO <u>cardiac arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>cardiac arrest</u> DUE TO <u>cardiac arrest</u> (c) <u>cardiac arrest</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerosis</u>			
19. WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>May 19 1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 21, 1959</u> , to <u>May 19, 1961</u> , that I last saw the deceased alive on <u>May 19, 1961</u> , and that death occurred at <u>6:51 P.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>L. C. Schwalbe</u> M.D.		ADDRESS (Street, city or town, state) <u>447 N. BELTSVILLE</u> DATE SIGNED <u>May 19 1961</u>	
PHYSICIAN'S NAME (Type) <u>L. C. Schwalbe</u>		<u>447 N. BELTSVILLE</u>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>May 19 1961</u>	<u>BELTSVILLE CEMETERY</u>	<u>BELTSVILLE</u> <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>John J. Schwalbe</u>		<u>447 N. BELTSVILLE</u>	
24a. REC'D BY REG. STRAR DATE <u>May 3 1961</u>		24b. REGISTRAR'S SIGNATURE <u>L. C. Schwalbe</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health before the burial is made.

VR A15 14
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Baltimore County		2 USUAL RESIDENCE Where deceased lived, if institution Residence a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt. Wilson		c. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) CLARKSBURG	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mt. Wilson State Hospital		e. STREET ADDRESS Rt. 1, Box 41	
3 NAME OF DECEASED (Type or print) ALEX SENIC		4. DATE OF DEATH Month 5 Day 22 Year 1961	
5 SEX M	6 COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/5/06
9 AGE In years (last birthday) 55 yrs.		10. FUNDING YEAR Months 55 Days 22 Hours 19 Min. 61	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL MINER		11b. KIND OF BUSINESS OR INDUSTRY GLITZIN, PENNA.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOSEPH SENIC	
14. MOTHER'S MAIDEN NAME MYTLE GABOR		15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 228-03-9783		17. INFORMATION Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for a, b, c) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE AURICULAR FLUTTER		INTERVAL BETWEEN ONSET AND DEATH 13 HOURS	
DUE TO ARTERIOSCLEROTIC HEART DISEASE		1 YR.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COMPLICATION GIVEN IN PART I PULMONARY TUBERCULOSIS, EMPHYSEMA		19. WAIVER OF AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. AGENT OF INJURY (If any) OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.) PULMONARY TUBERCULOSIS, EMPHYSEMA		20b. DISCRIBE HOW INJURY OCCURRED (State nature of injury and Part I.) While at work	
21. TIME OF INJURY Month 10 Day 7 Year 1960 Hour 8:35 a.m. PM		22. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) City or town	
23. I certify that I (this hospital) attended the deceased from 10/7 , 19 60 , to 5/22 , 19 61 the (1) (was) last saw the deceased alive on 5/22 , 19 61 , and that death occurred at 8:35 PM the causes and on the day stated above.		24. SIGNATURE William Newcomer NAME (Type) William Newcomer, M.D., Superintendent Mt. Wilson, Maryland	
25a. BURIAL (CREMATION) DATE THEREOF 5/22/61		25b. NAME OF CEMETERY OR CREMATORY CLARKSBURG	
26. FUNERAL DIRECTOR'S SIGNATURE FRANK NEWELL, PIKESVILLE, MD.		27. REC'D BY REGISTRAR MAY 17 '62	
28. REGISTRAR'S SIGNATURE C. H. H. H.		29. DATE MAY 17 '62	

MEDICAL CERTIFICATION



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

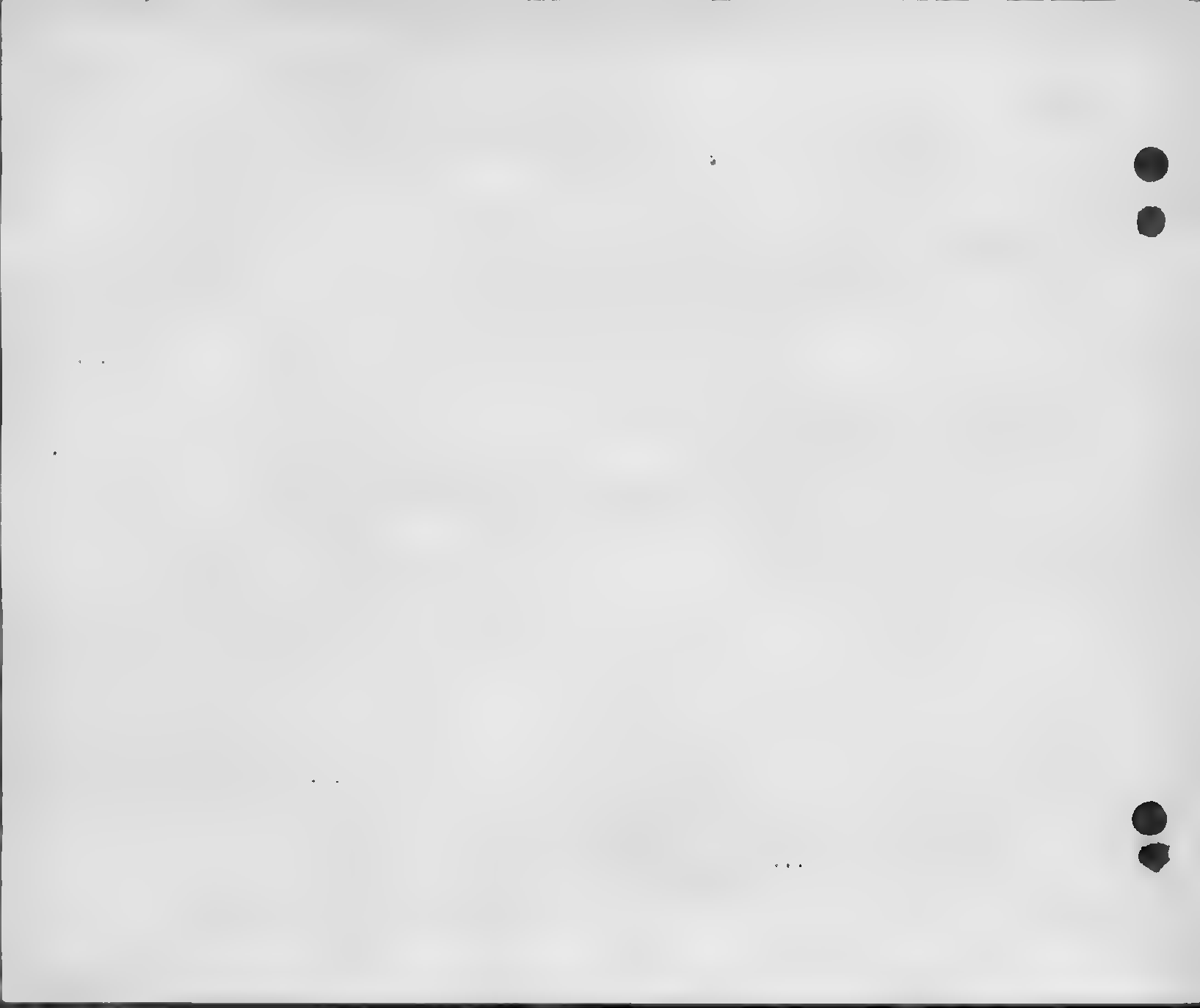
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05330

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Part 1) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN <u>Owings Mills</u> c. LENGTH OF STAY IN TB <u>23 years</u>		c. CITY OR TOWN <u>Baltimore City</u>	
NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rosewood St. Tr. School</u>		d. STREET ADDRESS <u>2903 Taylor Avenue</u>	
3 NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>H</u> Last <u>Shelley</u>		4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1961</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7/10/31</u>
9 AGE in years (last birthday) <u>29</u> yrs. Months <u>9</u> Days <u>19</u> Hours <u>61</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dependent</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTH PLACE <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Shelley</u>	
14. MOTHER'S MAIDEN NAME <u>Dorothy A. Gerwig</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Rosewood Records</u> Address <u>Owings Mills, Md</u>	
18 CAUSE OF DEATH (Enter only one cause per line for a and b) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE <u>11X</u> <u>Bronchopneumonia, bilateral, massive.</u> TO <u>11X</u> <u>Bronchiectasis</u> gave rise to immediate cause (a), stating the underlying cause last (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>Microgyria, external hydrocephalus</u>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of page 1b)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.)		20f. City or town, county, State	
21. I certify that <u>HE</u> (this hospital) attended the deceased from <u>4-18-38</u> 19 <u>38</u> to <u>5-19</u> 19 <u>61</u> , that <u>HE</u> (we) last saw the deceased alive on <u>5-19</u> 19 <u>61</u> , and that death occurred at <u>1:30 pm</u> the causes and on the date stated above.			
22a. SIGNATURE <u>Edward J. Mathews</u>		22b. DATE SIGNED <u>5-19-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward J. Mathews, M.D.</u>		22d. ADDRESS <u>Rosewood State Training School Box 109 Owings Mills, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/20/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem.</u>		23d. LOCATION (City, town or county, State) <u>Baltimore Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Rush</u>		24b. REC'D BY REGISTRAR <u>DATE MAY 23 '61</u>	
24c. ADDRESS <u>Baltimore Md.</u>		24d. REGISTRAR'S SIGNATURE <u>DATE</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death, and may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05331

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN b 3 Days		2. USUAL RESIDENCE (Where deceased lived at last illness) a. STATE Maryland		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If at a hospital, give street address) Veterans Administration Hospital						e. STREET ADDRESS 2113 McCulloh Street (17)			
3. NAME OF DECEASED (Type or print)		First EUGENE		Middle J.		Last SHIPLEY		4. DATE OF DEATH Month May Day 1 Year 19 61	
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 15, 1895		9. AGE, in years IF UNDER 1 YEAR IF UNDER 4 HRS last birthday Months Days Hours Mins 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Baltimore, Maryland		12. COUNTRY OF BIRTH U. S. A.			
13. FATHER'S NAME Joseph Shipley		14. MOTHER'S MAIDEN NAME Ida Johnson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes WW I					
16. SOCIAL SECURITY NO.		17. INFORMANT VA Hospital		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE PULMONARY EDEMA DUE TO CARCINOMA, PROSTATE WITH METASTASES TO BONE, PERITONEUM AND LYMPH NODES. DUE TO UNKNOWN					
19. NATURE OF UNDERLYING CAUSE (If either, NOTIFY MEDICAL EXAMINER) Necrotizing papillitis, left kidney. Chronic pyelonephritis, bilateral		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. P.M. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)		20f. CITY OR TOWN		20g. STATE		20h. COUNTRY	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 28, 1961 , to May 1, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 1, 1961 , and that death occurred at 1:50 P.M. from the causes and on the date stated above.									
22a. SIGNATURE <i>Thomas F. Crahan</i>		22b. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22c. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION		22d. DATE 5/2/61		22e. SIGNATURE <i>Herbert E. Nutter</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE OF May 4, 1961		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. Baltimore		23d. LOCATION (City, town or county) 28 Maryland		23e. STATE	
24. FUNERAL DIRECTOR'S SIGNATURE Herbert E. Nutter		24a. ADDRESS 3035 W. North Ave. Balto. 16, Md.		24b. DATE MAY 8 '61		24c. REGISTRAR'S SIGNATURE <i>James J. Thomas</i>		24d. DATE	



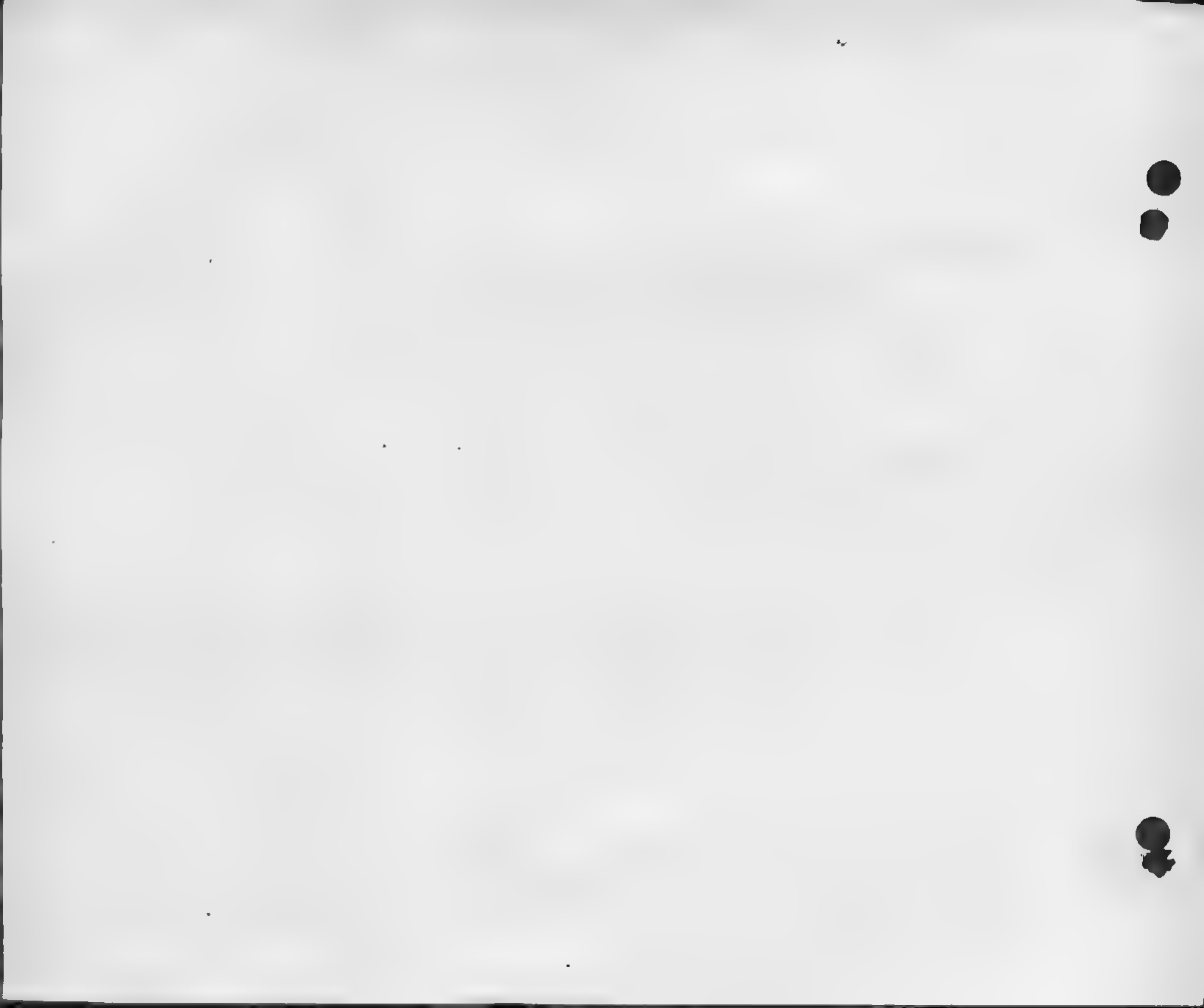
VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH

5240

115232

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write R.U.R.A. and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN TB <u>1yr 5mth 23dys</u>		c. CITY OR TOWN (If outside corporate limits, write R.U.R.A. and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Stella Machner, D.</u>		d. STREET ADDRESS <u>1308 Charles Street</u>		Is RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George</u>		First <u>George</u> Middle <u>Walter</u> Last <u>Balk</u>		4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1901</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		b. DATE OF BIRTH <u>April, 1901</u>		9. AGE (In years last birthday) <u>60</u>	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZENSHIP OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Records: Stella Machner, D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 2, 1959</u> , to <u>May 25, 1901</u> that I (we) last saw the deceased alive on <u>May 25, 1901</u> , and that death occurred at <u>1:30</u> M from the causes and on the date stated above.					
22a. SIGNATURE <u>Stella Machner, D.</u>		22b. ADDRESS <u>Catonsville, Md.</u>		22c. PHYSICIAN'S NAME (Type) <u>Stella Machner, D.</u>	
22d. DATE <u>5-25-01</u>		22e. SIGNATURE <u>Stella Machner, D.</u>		22f. ADDRESS <u>Catonsville, Md.</u>	
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION (City, town, or county)		(State)		23e. FUNERAL DIRECTOR'S SIGNATURE	
ADDRESS		23f. REC'D BY REGISTRAR DATE <u>MAY 28 '61</u>		23g. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>	



1
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.
may be signed by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

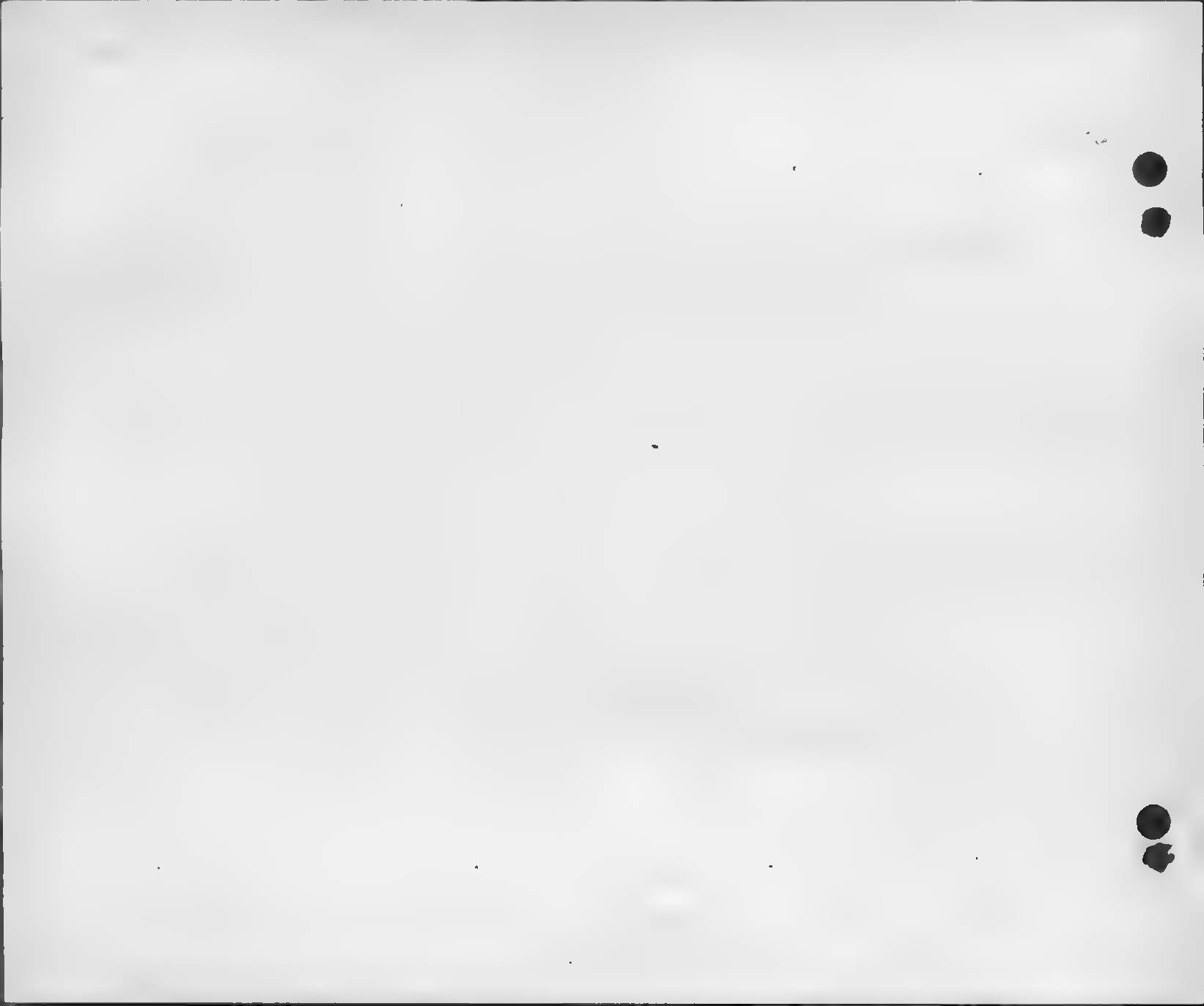
(M)

(I)

343
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05335

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ed</u> Middle <u>ward</u> Last <u>T. Smith</u>		4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2 1903</u>
9. AGE (in years, lost birthday) <u>63</u> yrs		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Mins <u>0</u> IF UNDER 24 HRS: Hours <u>0</u> Mins <u>0</u>	
10a. USCA. OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edward T. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth T. Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>24 months</u>		16. SOCIAL SECURITY NO. <u>24 00 0000</u>	
17. INFORMANT <u>Mrs. Edward T. Smith - S. Washington</u>		Address <u>1111 1st St. N.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>204-1</u> DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>Coronary atherosclerosis</u> (c) <u>Arteriosclerosis</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>100 AD 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120.</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u> 20c. TIME OF INJURY Month <u>May</u> Day <u>2</u> Year <u>1961</u> Hour <u>10</u> a.m. <u>10</u> p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Home</u> 20f. (City or town) <u>Baltimore</u> County <u>Baltimore</u> (State) <u>Md.</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>May 2 1961</u> to <u>May 2 1961</u> that (I, we) last saw the deceased alive on <u>May 2 1961</u> and that death occurred at <u>10</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>William H. H. H. H.</u>		22b. DATE SIGNED <u>May 2 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>William H. H. H. H.</u>		22d. ADDRESS <u>1111 1st St. N.E.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-5-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery</u>		23d. LOCATION (City, town, or county, State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. H. H. H.</u>		25a. REC'D BY REGISTRAR <u>1300 17th St.</u>	
25b. REGISTRAR'S SIGNATURE <u>Wm. J. H. H. H.</u>		DATE <u>MAY 2 '61</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5244

05336

1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if out of corporate limits write RURAL and give nearest town) North
c. LENGTH OF STAY IN 1b 11
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Joseph's Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution, give name of institution)
a. STATE MARYLAND
b. COUNTY Baltimore
c. CITY OR TOWN (if out of corporate limits write RURAL and give nearest town) North
d. STREET ADDRESS 286 Mason Court

3. NAME OF DECEASED (Type or print)
First Lee Middle J. Last Smith

4. DATE OF DEATH
Month May Day 19 Year 1961

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH June 4, 1904

9. AGE in years IF UNDER 1 YEAR IF UNDER 2+ HRS.
last birthday Months Day Hours Minutes 56 yrs

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed
10b. KIND OF BUSINESS OR INDUSTRY Interior Decorating

11. FATHER'S NAME Unknown 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no
16. SOCIAL SECURITY NO. none
17. INFORMANT Mr. Lee Smith-924 Southerly Road Address 924 Southerly Road

18. CAUSE OF DEATH [Enter only one cause per line for (e) (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Auto Collision
CONDITIONS, if any, which gave rise to immediate cause (b) Arteriosclerotic Cardiovascular Disease
(e), stating the underlying cause last. (c) Arteriosclerotic Cardiovascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS (OTHER THAN CAUSE OF DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS) (If any, state them here)
19. DATE OF ONSET OF DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS (If any, state them here)

20a. TIME OF INJURY (If any, state them here)
Hour a.m. p.m. 19
20b. DESCRIBE HOW INJURY OCCURRED (If any, state them here)
While at work ☐ Not while at work ☐

21. I certify that (a) (this person) attended the deceased from 1941 to 1961, that (b) (we) last saw the deceased alive on 19 and that death occurred at 11 M. from the causes and on the date stated above.

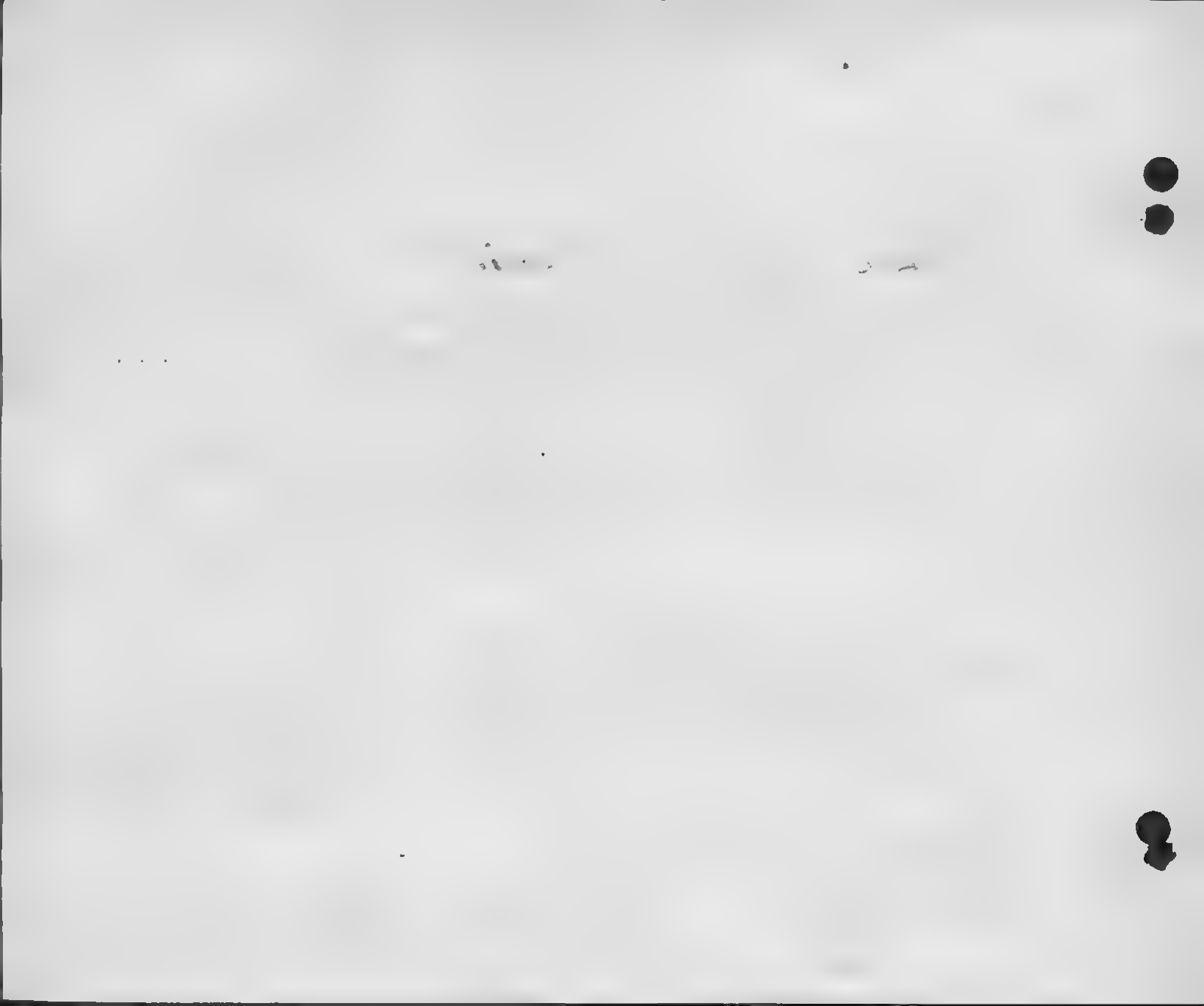
22. SIGNATURE Lee Smith 22b. DATE SIGNED May 16, 1961

22c. PHYSICIAN'S NAME Type Lee Smith 22d. ADDRESS North

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5-15-61
23c. NAME OF CEMETERY OR CREMATORY North 23d. LOCATION (City, town or county) Baltimore

24. FUNERAL DIRECTOR'S SIGNATURE North 25a. REC'D BY REGISTRAR 16 25b. REGISTRAR'S SIGNATURE 16

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



Page 4
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TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death.
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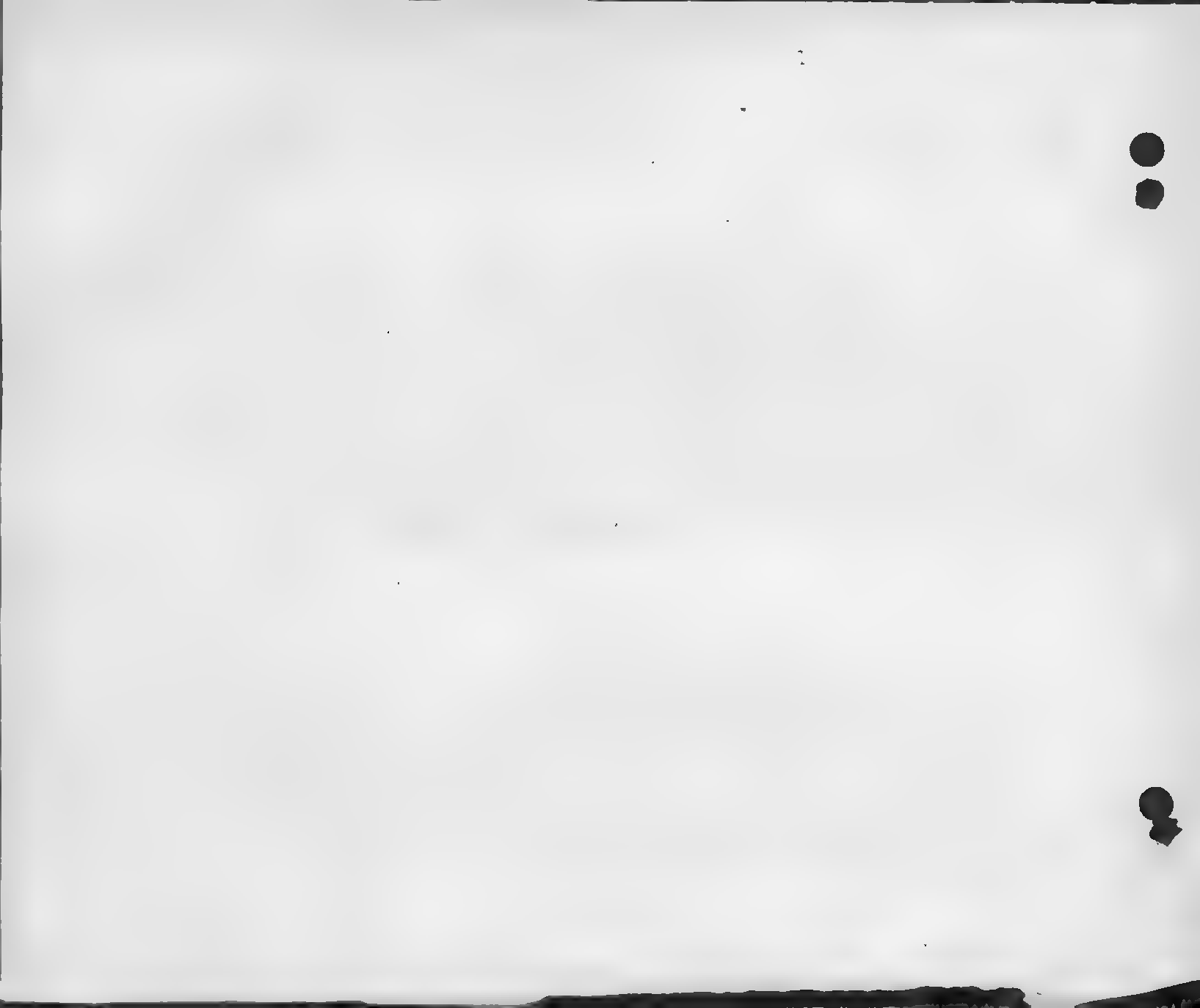
1961
MAY 29

5245
Item 8 Film 0220
01/2/61
15337

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown c LENGTH OF STAY IN 1b 26 days d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bent Nursing Home		2 USUAL RESIDENCE (Where deceased lived) a STATE Maryland b COUNTY Baltimore City c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City d STREET ADDRESS 2217 Linden Ave e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Mary Middle Smith Last Smith		4 DATE OF DEATH Month May Day 24 Year 1961	
5 SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 6 1881 9 AGE (in years) 80 last birthday Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursing Home Pt		10b KIND OF BUSINESS OR INDUSTRY U.S. Md	
11 BIRTHPLACE (State or foreign country) U.S.		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME J. Cobble		14 MOTHER'S MAIDEN NAME Elizabeth L.	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16 SOCIAL SECURITY NO Unknown	
17 INFORMANT Bent Nursing Home Records		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO (b) Cardiac Decompensation Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost Arteriosclerotic Cardio-Vascular Disease DUE TO (c) Indefinite PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I None INTERVAL BETWEEN ONSET AND DEATH			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None	
20c TIME OF INJURY Month Day Year Hour a.m. p.m. May 4 1961		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from May 4 1961 to May 24 1961 that (I) (we), last saw the deceased alive on May 20 1961 , and that death occurred at 11:30 P.M. from the causes and on the date stated above			
22a SIGNATURE George C. Medairy		22b DATE May 24 1961	
22c PHYSICIAN'S NAME (Type) George C. Medairy M.D.		22d ADDRESS 230 Main St Reisterstown, Maryland	
23a B. RIAL CREMATION REMOVAL Specify Interment		23b DATE THEREOF 5/27/61	
23c NAME OF CEMETERY OR CREMATORY St. Ignace Cemetery		23d LOCATION (City, town, or county) (State) Reisterstown, Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE W. H. ...		25a REG'D BY REGISTRAR 286 25b REGISTRAR'S SIGNATURE ...	
ADDRESS 32271 Snowden Rd		DATE May 28 1961	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5246

05338

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)
Catonsville
c. LENGTH OF STAY (If in hospital)
5mth 22dys
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
PRATT GRACE STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland
b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)
Capitol Heights, Maryland
d. STREET ADDRESS
819 Fifth Second Avenue

3. NAME OF DECEASED (Type or print)
First Middle Last
Maurice Marie Snyder

4. DATE OF DEATH
Month Day Year
May 14 19 61

5. SEX female 6. COLOR OR RACE white 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH
Dec. 31, 1893 9. AGE In years IF UNDER 1 YEAR IF UNDER 2 HRS
67 yrs Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife 10b. KIND OF BUSINESS OR INDUSTRY
At Home 11. BIRTHPLACE (Country, State, and County)
Washington, D. C. 12. CITIZEN OF WHAT COUNTRY?
U. S. A.

13. FATHER'S NAME John (Unknown) 14. MOTHER'S MAIDEN NAME
Idellie Randall

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes no, or unknown) (If yes give war or dates of service)
unknown 16. SOCIAL SECURITY NO. unknown 17. INFORMATION RECORDS: State of Maryland

18. CAUSE OF DEATH Enter only one cause per line for (a) (b) (c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terminal bronchopneumonia
arteriosclerotic brain disease
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last
Generalized arteriosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I
INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED?
YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month Day, Year Hour a.m. p.m.
19 10:35

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Capitol Heights, Maryland

20f. City or town (County) (State)
Catonsville 20, Maryland

21. I certify that (I) (this hospital) attended the deceased from Oct. 31 1960 to May 14, 1961 that (I) (we) last saw the deceased alive on May 14 1961, and that death occurred at 10:35 AM, from the causes and on the date stated above.

22a. SIGNATURE Stella Wachslar M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 5-15-61
22c. PHYSICIAN'S NAME (Type)
Stella Wachslar, M.D. 22d. ADDRESS
Capitol Heights, Maryland

23a. BURIAL, CREMATION REMOVAL (Specify)
BURIAL 23b. DATE THEREOF
MAY 18, 1961 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATL CEMETERY 23d. LOCATION (City, town or county) (State)
ARLINGTON VA.

24. FUNERAL DIRECTOR'S SIGNATURE
W. H. Chambers and Co. ADDRESS
517-11th St. S.E. Washington, D.C. 25a. RECD BY REGISTRAR
MAY 17 '61 25b. REGISTRAR'S SIGNATURE
Charles E. Krand

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 72 hours after death. The certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Undale 22</u>		<u>334</u>		TOWN <u>Undale 22</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>142 Chestnut Street</u>				STREET ADDRESS (If rural give locat on) <u>142 Chestnut St.</u>			
3. NAME OF DECEASED (Type or Print) <u>John Emmett Speed</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 25 1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct 5, 1892</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months Days Hours M n.		IF UNDER 24 HRS Hours M n.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker Steel Plant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sussex, Virginia</u>		11. BIRTHPLACE (State or foreign country, <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>World War I</u>				16. SOCIAL SECURITY NO. <u>213-07-2545</u>			
17. INFORMANT & ADDRESS <u>John Speed, Jr. 142 Chestnut St.</u>							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Leukemia</u>				<u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO <u>MITRAL STENOSIS</u>				<u>?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Rheumatic Heart Disease (old)</u>				<u>?</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MARCH 1948</u> to <u>May 25, 1961</u> , that I last saw the deceased alive on <u>May 25, 1961</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William C. Stale</u>		ADDRESS (Street, city, town, state) <u>140 Oak Avenue, Undale 22nd.</u>		DATE SIGNED <u>5/25/61</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-28-61</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>		ADDRESS <u>802 Madison Ave.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial (funeral) permit.

VS AISC 1 55 10M



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5349

CERTIFICATE OF DEATH

Reg. Dist No. 5340

1 PLACE OF DEATH a COUNTY BALTIMORE b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) BALTIMORE c LENGTH OF STAY IN 1b d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION ARACOST NURSING HOME 812 Regester		2 USUAL RESIDENCE (Where deceased lived If institution Resident before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 5701 CHINGUAPIN PARKWAY e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last HILDA HEINZ SPRINGER		4. DATE OF DEATH Month Day Year MAY 27, 1961 19	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 6-25-96
9 AGE (in years lost by yrs) 64		10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) BOOK KEEPER RETIRED F.N. BANK	
10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE MARYLAND		11 BIRTHPLACE (State or foreign country) U.S.A.	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME FREDERICK HEINZ	
14 MOTHER'S MAIDEN NAME MARY SEFTON		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO	
16 SOCIAL SECURITY NO 219-16-2569		17 INFORMANT MRS. ROLAND E. LAND WAGON	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Acidosis Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. Extensive pulmonary metastases - Carcinoma, right breast PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 12 hours 4 months 11 months		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I attended the deceased from August 11, 1960 to May 27, 1961 that I last saw the deceased alive on May 27, 1961 , and that death occurred at 9:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 840 Park Avenue Baltimore, Md. DATE SIGNED Patrick C. Phelan			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 31, 1961	
22c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEMETERY		22d. LOCATION (City, town or county) (State) PIKESVILLE MARYLAND	
23 FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTIMORE MD.		24a. REC'D BY REGISTRAR DATE 1 '61	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL: The attending physician: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
page 4
The law requires that the death certificate be executed within 24 hours of death by the attending physician or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

5349
MAY 31 1961
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

PLACE OF DEATH a. COUNTY <u>BALTO</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUMMIT CONV. HOME</u>		2. USUAL RESIDENCE (Where deceased lived, If institution or Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>SUMMIT CONV. HOME</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CARRIE SPRINGETT</u> First Middle Last 4. DATE OF DEATH <u>5/28</u> 19 <u>61</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>2/11/74</u> 9. AGE (In years last birthday) <u>87</u> yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> 11. BIRTHPLACE (State or foreign country) <u>Nor.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u> 14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>Baltimore Co. Welfare, Johnson</u> 17. INFORMANT <u>Johnson</u> Address <u>INTERVAL BETWEEN ONSET AND DEATH</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>Degenerative Heart Disease</u> (b) DUE TO <u>Chronic Bronch Syndrome</u> (c) DUE TO <u>Generalized Arteriosclerosis</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>Blindness</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year 19 <u>58</u> to <u>5/28/61</u> Hour a.m. p.m. <u>10:00 P.M.</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>Baltimore</u> (County) <u>Baltimore</u> (State) <u>MD</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>5/28/61</u> to <u>5/28/61</u> that (I) <u>last</u> saw the deceased alive on <u>5/28/61</u> and that death occurred <u>10:00 P.M.</u> from the causes and on the date stated above 22a. SIGNATURE <u>W.E. McGrath</u> 22b. PHYSICIAN'S NAME (Type) <u>W.E. McGrath</u> 22c. ADDRESS <u>303 Frederick Rd</u> 22d. CITY, TOWN, OR COUNTY <u>Baltimore</u> STATE <u>MD</u>		23a. BURIAL, CREMATION, or other disposition <u>Buried</u> 23b. DATE THEREOF <u>5/31/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u> 23d. LOCATION (City, town, or county) <u>Baltimore</u> STATE <u>MD</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. McRuff + Son</u> ADDRESS <u>- 28</u> 25a. REC'D BY REGISTRAR <u>1</u> 25b. REGISTRAR'S SIGNATURE <u>1</u> DATE <u>1</u>	



Page 4 of 4

VR A15 (4)
15M 9 59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15342

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Sparks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sparks Maryland</u>		d. STREET ADDRESS <u>Sparks, Maryland</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>LeRoy Stauffer</u>		4 DATE OF DEATH Month <u>5</u> Day <u>13</u> Year <u>1961</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-29-1927</u>
9 AGE (In years last birthday) <u>73</u> yrs	10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Farm</u>
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>UNKNOWN</u>		14 MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO <u>217-22-8015</u>	
17 INFORMANT <u>Alice Hidey Sparks, Maryland</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>9/2/61</u>			
(b) <u>Hypertensive Cardiovascular Disease</u> DUE TO <u>9/2/61</u>			
(c) <u>Arteriosclerosis (Calcification of Arteries)</u> DUE TO <u>9/2/61</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
19 WA AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>1961</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)		20f City or town, county, (State)	
21 I certify that () (this hospital) attended the deceased from <u>1-1-1959</u> to <u>5-13-1961</u> that (I/we) last saw the deceased alive on <u>5-12-1961</u> , and that death occurred at <u>7:15 AM</u> from the causes and on the date noted above			
22a SIGNATURE <u>C. HERBERT MUELLER</u>		22b ADDRESS <u>PAF to ...</u>	
22c PHYSICIAN'S NAME (Type) <u>C. HERBERT MUELLER</u>		22d ADDRESS <u>PAF to ...</u>	
23a BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>5-16-61</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Jessops Methodist</u>		23d LOCATION (City, town, or county, State) <u>Sparks Maryland</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Prooks Funeral Service Towson Maryland</u>		25a REC'D BY REGISTRAR <u>MAY 1961</u>	
25b REGISTRAR'S SIGNATURE <u>Shirley S. ...</u>			

THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The attending physician and completely filled in by the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05343

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY (In 1b) 3 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived for 1 year or more) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 9 E. Centre Street (2)	
3. NAME OF DECEASED (Type or print) FREDERICK C. STECKER		4. DATE OF DEATH Month May Day 25 Year 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3, 1894	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Maker		10b. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co. Baltimore, Maryland	
13. FATHER'S NAME John L. Stecker		14. MOTHER'S MAIDEN NAME Anna Grief	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch and service) Yes WW I		17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE CONGESTIVE HEART FAILURE DUE TO ARTERIOSCLEROTIC HEART DISEASE DUE TO UNKNOWN		19. INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I) 1. PULMONARY TUBERCULOSIS, MODERATELY ADVANCED, ACTIVE- Duration Unknown 2. Benign prostatic hypertrophy.			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 19		20f. CITY OR TOWN 1961	
21. I certify that (this hospital) attended the deceased from May 22, 1961 to May 25, 1961 , that (we) last saw the deceased alive on May 25, 1961 , and that death occurred at 2:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE OF PHYSICIAN Thomas F. Crahan		22b. ADDRESS VAH, BALTO. 18, MD., FT. HOWARD DIVISION	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. DATE 5/26/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-29-61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore 28 Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd. Balto. 14, Md.		25a. RECEIVED BY REGISTRAR MAY 29 1961	
		25b. REGISTRAR'S SIGNATURE Arthur S. Krause	

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VS AIS (4)
15M 9/58

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived first 10 years of life) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARK FAL</u>		d. STREET ADDRESS <u>CLYDE ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>JEAN</u> Middle <u>STEINER</u> Last <u>STEINER</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>27</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 25, 1879</u> AGE (In years last birthday) <u>82</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>
13. FATHER'S NAME <u>JACOB STEINER</u>		14. MOTHER'S MAIDEN NAME <u>JOHANNA FRANK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-26774</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>hypertension</u> DUE TO (c) <u>arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 25, 1961</u> to <u>May 30, 1961</u> that I last saw the deceased alive on <u>May 30, 1961</u> , and that death occurred at <u>6:00</u> P.M., from the causes and on the date stated above			
ACTUAL SIGNATURE <u>H. M. FRANCE</u> MD		DATE SIGNED <u>June 2, 1961</u>	
PHYSICIAN'S NAME (Type) <u>H. M. FRANCE</u>			
22a. BURIAL OR CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-3-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mifflinville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mifflinville, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein, New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>61</u> 24b. REGISTRAR'S SIGNATURE <u>C. J. Hartenstein</u>	



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5252

Page 4

TO HOSPITAL or to the funeral home. The law requires that the death certificate be executed within 24 hours of death. The law requires that the attending physician, the hospital or attending physician, may be required to sign the certificate. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL or to the funeral home. The law requires that the death certificate be executed within 24 hours of death. The law requires that the attending physician, the hospital or attending physician, may be required to sign the certificate. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15345

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> c. LENGTH OF STAY IN 1b <u>12020</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bent Nursing Home Reisterstown Rd</u>		2 USUAL RESIDENCE (Where deceased lived) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City (1)</u> d. STREET ADDRESS <u>3115</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>STEWART</u> Last <u>STEWART</u> 4. DATE OF DEATH Month <u>MAY</u> Day <u>27</u> Year <u>1961</u>		5 SEX <u>Male</u> 6 COLOR OR RACE <u>Colored</u> 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8 DATE OF BIRTH <u>9/15/18</u> 9 AGE (in years lost birthday) <u>85</u> yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chaffeur</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Reisterstown</u> 11 BIRTHPLACE (State or foreign country) <u>Reisterstown</u> 12 CITIZEN OF WHAT COUNTRY? <u>Indefinite</u>	
13 FATHER'S NAME <u>WILLIAM STEWART</u> 14 MOTHER'S MAIDEN NAME <u>ELIZABETH</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u> 16 SOCIAL SECURITY NO. <u>None</u> 17 INFORMANT <u>Mrs Nancy Tang</u> Address <u>Reisterstown</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> Conditions (b) <u>Indefinite</u> gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Indefinite</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>None</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>May 4, 1961</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>230 Main St., Reisterstown, Md.</u> 20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>May 4, 1961</u> to <u>May 27, 1961</u> that (I) (we) last saw the deceased alive on <u>May 26, 1961</u> and that death occurred at <u>10 PM</u> from the causes and on the date stated above			
22a. SIGNATURE <u>George C. Medaury</u> M.D. 22b. PHYSICIAN'S NAME (Type) <u>George C. Medaury M.D.</u>		22c. ADDRESS <u>230 Main St., Reisterstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-31-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Cem.</u>		23d. LOCATION (City, town or county, State) <u>Reisterstown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas A. Hemmley</u> ADDRESS <u>578 W. Biddle St.</u>		25a. REC'D BY REGISTRAR <u>DATE: 5/30/61</u> 25b. REGISTRAR'S SIGNATURE	





TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05347

1. PLACE OF DEATH
a. COUNTY **Baltimore**
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Fort Howard**
c. LENGTH OF STAY IN 1b **13 days**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Veterans Administration Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE **Maryland**
b. COUNTY **Baltimore**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **418 S. Monroe Street-23**
d. STREET ADDRESS **Baltimore**

3. NAME OF DECEASED
First **FRANCIS** Middle **J.** Last **STILLING**

4. DATE OF DEATH
Month **May** Day **21** Year **1961**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH **June 15, 1911** 9. AGE in years (last birthday) **49** yrs. IF UNDER 1 YEAR: Months **4** Days **1** IF UNDER 24 HRS: Hours **1** Min. **4**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Truck Driver** 10b. KIND OF BUSINESS OR INDUSTRY **Self Produce** 11. BIRTHPLACE (County & State, or foreign country) **Baltimore, Maryland** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13. FATHER'S NAME **Anthony J. Stilling** 14. MOTHER'S MAIDEN NAME **Theresa Schalitzy**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **Yes WW-11** 16. SOCIAL SECURITY NO **216-28-7873** 17. INFORMANT **Clinical Records, 300 Loch Raven Blvd. Balto 18, Md-FORT HOWARD DIVISION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **CARCINOMA OF ESOPHAGUS WITH WIDESPREAD METASTASIS**
DUE TO **150X**
Conditions, if any, which gave rise to immediate cause (b) **6 wks**
(a), stating the underlying cause last
DUE TO
PART II OTHER SIGNS AND CONDITIONS CONTRIBUTING TO DEATH (If NOT RELATED TO THE TERMINAL ILLNESS, ENTER HERE)
Esophagoscopy and Bronchoscopy with tissue biopsy 5/11/61

20a. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 2, Part 1 or 2, if either, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year **May 8 7:15 1961** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **VA Hospital, Fort Howard, Maryland** 20f. (City or town) **Baltimore** (County) **Maryland** (State)

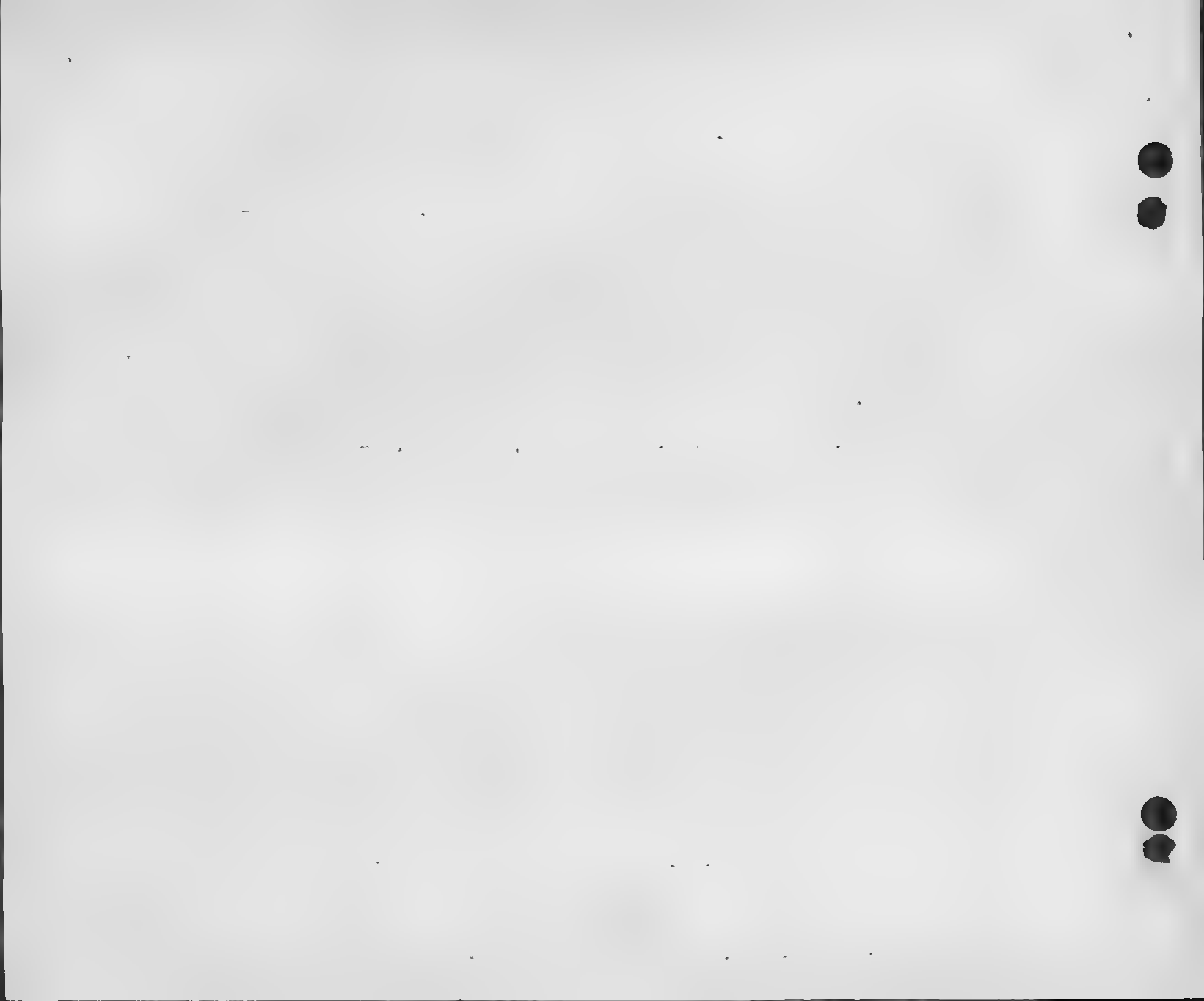
21. I certify that ☒ (this hospital) attended the deceased from **May 8 7:15 1961** to **May 21, 1961** that **1** (we) last saw the deceased alive on **May 21, 1961**, and that death occurred at **11 A.M.** from the causes and on the date stated above.

22a. SIGNATURE **Armen Bogosian** 22b. DATE SIGNED **May 21, 1961**

22c. PHYSICIAN'S NAME (Type) **ARMEN BOGOSIAN, M.D.** 22d. ADDRESS **VA Hospital, Fort Howard, Maryland**

23a. BURIAL CREMATION REMOVAL (Specify) **Burial** 23b. DATE THEREOF **5/25/61** 23c. NAME OF CEMETERY OR CREMATORY **Baltimore National 6009 Harford Road** 23d. LOCATION (City, town, county, state) **Baltimore Maryland**

24. FUNERAL DIRECTOR'S SIGNATURE **William Cook-Blight, Inc.** 25a. REC'D BY REGISTRAR **DATE MAY 24 '61** 25b. REGISTRAR'S SIGNATURE **Clifford E. Kline**



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5356

05348

M

1. PLACE OF DEATH
a. COUNTY Baltimore **MARYLAND**
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Reisterstown
c. LENGTH OF STAY (If in hospital, give street address) Sparrows Point
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bent Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Sparrows Point
d. STREET ADDRESS 502 F Street

3. NAME OF DECEASED (Type or print) First Middle Last
JAMES WILBUR STIMELING

4. DATE OF DEATH Month Day Year
May 2, 1961

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH
May 11, 1885 9. AGE (In years: If UNDER 1 YEAR, last birthday; Months; Days; Hours; Min.) 75 yrs

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane operator 10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co. 11. BIRTHPLACE (County & State or foreign country) Pennsylvania 12. CITIZEN OF WHAT COUNTRY? U.S.A.

I

13. FATHER'S NAME James M. Stimeling 14. MOTHER'S MAIDEN NAME Henrietta Lyter

15. WAS DECEASED EVER IN U.S. ARMED FORCES. (Yes, no, or unknown) (If yes, give year or dates of service) 1908-1911 16. SOCIAL SECURITY NO. 213-07-5262 17. INFORMANT Cyrus Stimeling Address 439 Jackson St. Camden-4, N.J.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE (e) Cerebral hemorrhage
(b) General arteriosclerotic hypertension
(c) Ischemic heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 20. INTERVAL BETWEEN ONSET AND DEATH 3 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
Ischemic heart disease following an operation to repair a prosthesis

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
Operation to repair a prosthesis

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. May 1, 1961 5:15 p.m. 20d. INJURY OCCURRED While at work ☐ Not while at work ☒ 20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc. Home 20f. City or town (County, State) Baltimore, Md.

21. I certify that (I) (this hospital) attended the deceased from 5-1-61 to 5-2-61, that (I) (we) last saw the deceased alive on 5-1-61, and that death occurred at 5:15 p.m. from the causes and on the date stated above

22a. SIGNATURE James G. Saffer M.D. 22b. DATE SIGNED 5-2-61

22c. PHYSICIAN'S NAME (Type) James G. Saffer 22d. ADDRESS Reisterstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5/5/61 23c. NAME OF CEMETERY OR CREMATORY Baltimore National 23d. LOCATION City, town or county State Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ullrich Funeral Home Dundalk, Md. 25a. REC'D BY REGISTRAR MAY 4 '61 25b. REGISTRAR'S SIGNATURE Charles L. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



Page 4
 TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9-59

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5353 115341

1 PLACE OF DEATH a. COUNTY MARYLAND		2 USUAL RESIDENCE (Where deceased lived f. inst. at on Residence before adm. on) a. STATE Md b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) 3		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) 130.10. more	
c. LENGTH OF STAY IN 1b 23 days		d. STREET ADDRESS 3541 Reswick Rd	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Johns Hopkins		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Sadia Pearl Stitely		4 DATE OF DEATH Month Day Year 5 19 1961	
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/7/190
9 AGE (in years last birthday) 70 yrs		10 F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator Cotton mill		10b KIND OF BUSINESS OR INDUSTRY Md	
11 BIRTHPLACE (State or foreign country) U.S.A		12 CITIZEN OF WHAT COUNTRY? U.S.A	
13 FATHER'S NAME George W Stitely		14 MOTHER'S MAIDEN NAME Sarah Martini	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO 215-07-6653	
17 INFORMANT Reswick Rd		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiac vascular disease + 22.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 1) Pulmonary tuberculosis 2) Simple emphysema			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either NOT BY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home farm, factory, street, office, bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 4/25 1961 to 5/19 1961 that (I) (we) last saw the deceased alive on 5/19 1961 , and that death occurred at 11:20 M from the causes and on the date stated above			
22a SIGNATURE John Stitely		22b DATE 5/19/61	
22c PHYSICIAN'S NAME (Type) John Stitely		22d ADDRESS 3541 Reswick Rd	
23a BURIAL CREMATION REMOVAL (Specify) MAILED 3/61		23b DATE THEREOF MAILED 3/61	
23c NAME OF CEMETERY OR CREMATORY WILMINGTON CATHOLIC		23d LOCATION (City, town or county, state) WILMINGTON, DE	
24 FUNERAL DIRECTOR'S SIGNATURE John Stitely		25 REGISTRAR'S SIGNATURE John Stitely	
ADDRESS 3617 West 1st Ave.		DATE MAY 24 '61	

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TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: The low requires that the attending physician and cemetery be filled in by the funeral director.
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15 (4)
15M 9/59

355
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05350

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived) f. Institution Residence before admission a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>23yr10mth21dys</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Davidsonville, Maryland</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>SPRING CROWE STATE HOSPITAL</u>		d. STREET ADDRESS <u>221</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>V.</u> Last <u>Stockett</u>		4 DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1961</u>	
5 SEX <u>female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec 31, 1879</u>
9 AGE (In years) <u>81</u> yrs		IF UNDER 1 YEAR: Months <u>1</u> Days <u>22</u> Hours <u>0</u> Mins <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11 BIRTHPLACE (State or foreign country) <u>unknown Maryland</u>
12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Records: SPRING CROWE STATE HOSPITAL</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Terminal pulmonary thrombosis and infarction</u>			
DUE TO (b) <u>arterio-sclerotic cardiovascular disease</u>			
DUE TO (c) <u>Generalized arteriosclerosis</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>Gangrene of the left leg</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11:30</u> p. m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that () (this hospital) attended the deceased from <u>July 1, 1957</u> to <u>May 23, 1961</u> that (I) (we) last saw the deceased alive on <u>May 23, 1961</u> and that death occurred at <u>11:30 P. M.</u> from the causes and on the date stated above.			
22a SIGNATURE <u>Stella Wachslar</u> M.D.		22b DATE SIGNED <u>5-24-61</u>	
22c PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		22d ADDRESS <u>Catonsville 28, Maryland</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>May 27, 1961</u>	
23c NAME OF CEMETERY OR CREMATORY <u>All Hallows Cemetery</u>		23d LOCATION (City, town, or county) (State) <u>Davidsonville, Maryland</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Hopkins Funeral Home</u>		25 ADDRESS <u>Annapolis, Maryland</u>	
25a REC'D BY REGISTRAR <u>6</u>		25b REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1359

05351

1. PLACE OF DEATH
 a. COUNTY Baltimore
 b. CITY OR TOWN (If out of corporate limits write RURAL and give nearest town) Middlesex
 c. LENGTH OF STAY IN (b) 1
 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 233 Orville Road
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
 a. STATE Md.
 b. COUNTY Baltimore
 c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Middlesex
 d. STREET ADDRESS 233 Orville Road
 e. RACE NO
3. NAME OF DECEASED
 First JAMES A. STRICKER (STREJCEK) Last May 4 19 61
4. SEX male **5. COLOR OR RACE** white **6. MARRIED** ☐ NEVER MARRIED ☐ **7. DATE OF BIRTH** 9/26/1896
8. AGE 64 **9. AGE IN YEARS** 64 **10. MONTHS** 0 **11. DAYS** 0 **12. HOURS** 0 **13. MIN.** 0
14. OCCUPATION (If not doing work, state if retired) Cab Driver - Old Grey Hound Cab Co. **15. KIND OF BUSINESS OR INDUSTRY** Baltimore, Md. **16. COUNTRY** U.S.A.
17. FATHER'S NAME Joseph Strejcek **18. MOTHER'S MAIDEN NAME** Catherine Patrick

19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO **20. SOCIAL SECURITY NO.** 214-01-5087 **21. INFORMANT** Shirley Jachimski, daughter, above
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Coronary Occlusion
 DUE TO Arteriosclerotic coronary vascular disease
 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. 1 year
 DUE TO 1 year
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
23. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

24. MEDICAL CERTIFICATION
 24a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING () CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
 24b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
 24c. TIME OF INJURY Month, Day, Year May 7, 1961
 Hour a.m. 19 p.m. 19
 24d. INJURY OCCURRED While at work ☐ Not While at work ☐
 24e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 12106 ORCHES RD BALT. 20, Md.
 24f. (City or town) Baltimore County Md. (State) Md.
 21. I certify that (I) (this hospital) attended the deceased from May 7, 1961 to May 7, 1961, that (I) (we) last saw the deceased alive on May 4, 1961 and that death occurred at 11 A.M. from the causes and on the date stated above
 22a. SIGNATURE Louis Samunoff M.D. **22b. DATE SIGNED** 5/8/61
 22c. PHYSICIAN'S NAME Type Louis Samunoff
23. BURIAL CREMATION 23b. DATE THEREOF 5/8/61 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. 23d. LOCATION (City, town or county) Baltimore, Md. (State) Md.

24. FUNERAL DIRECTOR'S SIGNATURE Schmunek Funeral Home, Inc. ADDRESS 2601 E. Madison St.
25. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Arthur S. Kneass
 DATE MAY 9 '61

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. It must be retained by the hospital or attending physician. TO HOSPITAL: This certificate must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

Reg Dist No 05352

Page 4

with 24 hr

by the funeral director

Pages 1 and 2 should be filled with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

The law requires that the death certificate be executed within 24 hr

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director

page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

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1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>BALTIMORE</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>CATON RIDGE HOME</u>				d. STREET ADDRESS <u>1404 RAMSAY ST</u>			
3. NAME OF DECEASED First Middle Last <u>CATHERINE (KATIE) C. THATER</u>				4. DATE OF DEATH Month Day Year <u>MAY 10 1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>15 FEB 1867</u>	
9. AGE (in years last birthday) <u>94</u> yrs		F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO MD</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>CONRAD DILL</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO <u>NONE</u>			
17. INFORMANT <u>WILLIAM M. CARLEY</u>				Address <u>306 GILMAN ST</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular failure</u>							<u>1 day</u>
DUE TO <u>arteriosclerosis</u>							<u>unknown</u>
DUE TO <u>age</u>							<u>L</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>Bed Sores, embolus, heart disease, old CVA</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY Home farm factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>4/20</u> , 19 <u>61</u> to <u>5/10</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>5/7</u> , 19 <u>61</u> , and that death occurred at <u>2:10 PM</u> , from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Cliff Ratcliff, Jr</u>				ADDRESS (Street, city or town, state) <u>4605 EDMONDSON AVE BALTO 29, MD</u>			
DATE SIGNED <u>5/10/61</u>							
PHYSICIAN'S NAME (Type) <u>CLIFF RATCLIFF, JR</u>				ADDRESS <u>BALTO 29, MD</u>			
22a. BURIAL, CREMATION, or other disposition (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>13 MAY 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESTERN CEM</u>	
22d. LOCATION (City, town or county) <u>BALTO MD</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter H. Harker</u>				ADDRESS <u>Walter H. Harker</u>		24a. REC'D BY REGISTRAR <u>Walter H. Harker</u>	
DATE <u>MAY 11 1961</u>				24b. REGISTRAR'S SIGNATURE <u>Walter H. Harker</u>			



CERTIFICATE OF DEATH

Reg. Dist. No. 05253

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived first full year before admission) a. STATE <u>MD.</u> b. COUNTY <u>11</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>833 Street 88 Ave</u>		e. STREET ADDRESS <u>5-3-1100-1094</u>	
3 NAME OF DECEASED (Type or print) <u>Harold Hermann</u>		4. DATE OF DEATH Month <u>5</u> Day <u>31</u> Year <u>19</u>	
5 SEX <u>M.</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8-25-76</u>
9 AGE (In years last birthday) <u>21</u> yrs		10 IF UNDER 1 YEAR: Months <u>2</u> Days <u>28</u> Hours <u>10</u> Min <u>40</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11 BIRTHPLACE (State or foreign country) <u>MD.</u>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <u>John H.</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth C. H.</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO. <u>1-25-76</u>	
17 INFORMANT <u>Family - Dr. H.</u>		Address <u>1100-1094</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>			
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u>			
(c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town (County) (State)	
21 I certify that I attended the deceased from <u>July 14</u> , to <u>17 May 1961</u> , that I last saw the deceased alive on <u>17 May 1961</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Charles H. Teier</u> M.D.		ADDRESS (Street, city or town, state) <u>6701 York Rd Baltimore Md</u>	
PHYSICIAN'S NAME (Type) <u>Charles H. Teier</u>		DATE SIGNED <u>18 May 1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
23 FUNERAL DIRECTOR'S SIGNATURE <u>W. C. F. T. W.</u>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>MAY 19 1961</u>			

ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



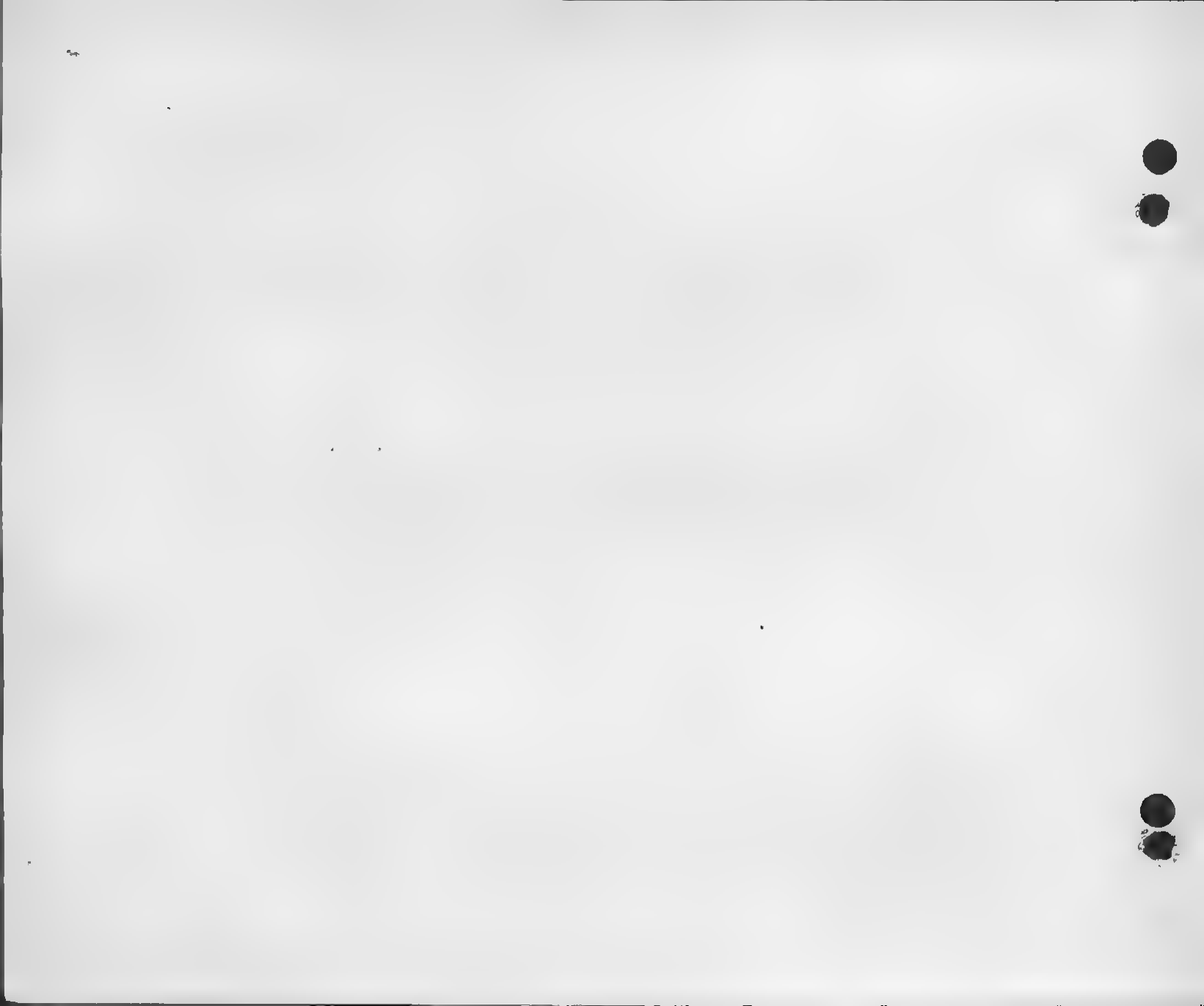
ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The attending physician or attending physician on the hospital or attending physician on the funeral home must sign the certificate. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

5362

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15354

1. PLACE OF DEATH a. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRIENDLY VILLAGE c. LENGTH OF STAY IN b 18 months d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8457 CADRETT RD. S.E.		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRIENDLY VILLAGE d. STREET ADDRESS 8457 CADRETT RD. S.E.	
3. NAME OF DECEASED (Type or print) First SIDNEY Middle I Last THURNE		4. DATE OF DEATH Month MAY Day 15 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 25 1883
9. AGE (In years last birthday) 77		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY GENERAL FARMING	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL CLAGGETT		14. MOTHER'S MARDEN NAME LUCY ANN BARRETT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Hospital records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 102X DUE TO (c)	
19. WAS A TOPY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II or item 18) ARTERIAL SCLEROTIC CARDIOVASCULAR DISEASE	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/23 1957 to 5/19 1961 that (I) (we) last saw the deceased alive on 5/17 1961 and that death occurred at 10 P M from the causes and on the date stated above		22a. SIGNATURE William Thurne	
22b. PHYSICIAN'S NAME (Type) William Thurne		22c. ADDRESS 1661 Good Hope Rd S.E.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF May 22, 1961	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION City, town, or county 4000 Sweetland Rd. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James Bros		25a. REGD BY REGISTRAR DATE MAY 24 1961	
25b. REGISTRAR'S SIGNATURE			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5363

CERTIFICATE OF DEATH

Reg. Dist. No. 5355

1 PLACE OF DEATH a COUNTY <u>MD</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <u>MD</u> b COUNTY <u>3</u>	
b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MD</u>		c LENGTH OF STAY IN 1b <u>MD</u>	
d NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>MD</u>		e STREET ADDRESS <u>MD</u>	
3 NAME OF DECEASED (Type or print) <u>Estelle R. Troun</u>		4 DATE OF DEATH <u>May 19 1961</u>	
5 SEX <u>1</u>	6 CO. OR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 11, 1910</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>MD</u>	11 BIRTHPLACE (State or foreign country) <u>MD</u>
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>Theodore T. Beery</u>	
14 MOTHER'S MAIDEN NAME <u>Isabelle Paul</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give name and dates of service) <u>No</u>	
16 SOCIAL SECURITY NO. <u>MD</u>		17 INFORMANT <u>Mr. Ralph W. Troun</u> Address <u>MD</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 450.1 DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>MD</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>5 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MD</u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year <u>May 23 1961</u> Hour, <u>8:30</u> p.m.	20d INJURY OCCURRED <u>While at work</u> <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) <u>MD</u>	20f (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 3</u> , 19 <u>61</u> , to <u>May 23</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>May 20</u> , 19 <u>61</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John V. Conway, M.D.</u>		ADDRESS (Street, city or town, state) <u>94 D St Balt 19 MD</u>	
PHYSICIAN'S NAME (Type) <u>John V. Conway, M.D.</u>		DATE SIGNED <u>5 24 61</u>	
22a BURIAL, CREMATION, REMOVAL (Specify)	22b DATE THEREOF <u>May 24 1961</u>	22c NAME OF CEMETERY OR CREMATORY <u>MD</u>	22d LOCATION (City, town, or county) (State)
23 FUNERAL DIRECTOR'S SIGNATURE <u>MD</u>		ADDRESS <u>MD</u>	24a REC'D BY REGISTRAR <u>MD</u>
24b REGISTRAR'S SIGNATURE <u>MD</u>		DATE <u>MD</u>	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove the top papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5864

CERTIFICATE OF DEATH

Reg. Dist. No. 15356

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c LENGTH OF STAY IN lb <u>10</u> yrs	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glen Falls Road</u>		e STREET ADDRESS <u>Glen Falls Road</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Harry Vinton Uhler</u>		4. DATE OF DEATH Month Day Year <u>May 27, 1961</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct. 20, 1877</u>
9 AGE (In years last birthday) <u>83</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Andrew J. Uhler</u>		14. MOTHER'S MAIDEN NAME <u>Mary Reyland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>None</u>	
INFORMANT <u>Mrs. Carl Durham, Pinksburg,</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Myocardial infarction</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 19 WA. AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day, Year Hour a m p m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 22, 1961</u> to <u>May 27, 1961</u> , that I last saw the deceased alive on <u>May 26, 1961</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Reisterstown, Md.</u> DATE SIGNED <u>May 27, 1961</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u> PHYSICIAN'S NAME (Type) <u>[Name]</u>			
22a BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b DATE THEREOF <u>May 31, 1961</u>	
22c NAME OF CEMETERY OR CREMATORY <u>Mary Cemetery</u>		22d LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Line & Sons, Reisterstown, Md.</u>		24a REC'D BY REGISTRAR DATE <u>JUN 1 '61</u>	
ADDRESS		24b REGISTRAR'S SIGNATURE <u>Clara J. Hines</u>	



TO HOSPITAL: The law requires that the death certificate be executed within 48 hours after death. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

M

365
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05357

1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATON'S CREEK
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 204 BLOOMSBURY AVE
2. USUAL RESIDENCE Where deceased lived prior to death
a. STATE MD
b. COUNTY BALTIMORE
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATON'S CREEK
d. STREET ADDRESS 204 BLOOMSBURY AVE
3. NAME OF DECEASED (Type or print)
First Middle Last
K. AMALIA VAN VORST
4. DATE OF DEATH
Month Day Year
MAY 7 1961
5. SEX F
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ R. DATE OF BIRTH
SEPT 9, 1887
9. AGE (In years, if under 1 year, give months and days)
27 yrs.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired
HOUSEKEEPER
10b. KIND OF BUSINESS OR INDUSTRY HOME
11. CITIZENSHIP OF DECEASED NEW JERSEY
12. FATHER'S NAME WILLIAM GULDEN
13. MOTHER'S MAIDEN NAME CHARLOTTE
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or service)
NO
15. SOCIAL SECURITY NO
16. INFORMANT
Address
Caton's Creek
17. CAUSE OF DEATH (Enter only one cause per line, for a and b)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO
b. Chronic Hypertensive Cardiovascular Disease
18. CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.
DUE TO
c.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.
19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED Enter nature of injury in Part II of form
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19
20d. INJURY OCCURRED
While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. City or town
20g. State
21. I certify that (I) (this hospital) attended the deceased from 11-15-1943 to 5-7-1961, that (I) (we) last saw the deceased alive on 5-6-1961 and that death occurred at 3PM, from the causes and on the date stated above
22a. SIGNATURE
22b. DATE SIGNED
5-8-61
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS
6229 Frederick Ave, Baltimore 28, Md.
23a. BURIAL CREMATION, 23b. DATE THEREOF
REMOVAL (Specify)
5-9-61
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town or county)
(State)
24. FUNERAL DIRECTOR'S SIGNATURE
25a. REC'D BY REGISTRAR
25b. REGISTRAR'S SIGNATURE
DATE 5-12-61

VR A15 (4)
15M 9/60



TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5366

05258

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE Where deceased lived, or institution a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Paradise Nursing Home		d. STREET ADDRESS 1131 McAleer Court	
3. NAME OF DECEASED (Type or print) Paradise and Altamont Aves		4. DATE OF DEATH Month May Day 19 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1886
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md	
13. FATHER'S NAME John Steven Waldsachs		14. MOTHER'S MAIDEN NAME Hannah Wissern	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		17. INFORMANT 212-07-3123 Ross S. Waldsachs, 1131 McAleer Court, Zone 2	
18. CAUSE OF DEATH (Enter only one cause for a, b, c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE a. DUE TO (b) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last c. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Acute Congestive Heart Failure with Atrial Fibrillation Coronary Artery with Myocardial Infarction			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.) Home	20f. City or town, County, State Baltimore
21. I certify that (I) (this hospital) attended the deceased from 4/19/61 to 5/19/61 , that (I) (we) last saw the deceased alive on 5/19/61 , and that death occurred 5/19/61 M. from the causes and on the date stated above.			
22a. SIGNATURE W.E. McGrath MD		22b. DATE SIGNED 5/22/61	
22c. PHYSICIAN'S NAME (Type) W.E. McGrath MD		22d. ADDRESS 1303 Frederick Rd (28)	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-23-61	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION City, town or county (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR MAY 24 1961	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5367

05359

1 PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN Baltimore
c. LENGTH OF STAY 11 b
d. NAME OF HOSPITAL OR INSTITUTION 2608 Lockwood Road

2 USUAL RESIDENCE (Where deceased lived in institution, residence at time of death)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN Baltimore
d. STREET ADDRESS 2608 Lockwood Road

3. NAME OF DECEASED (Type or print)
First Harold Middle Marshall Last Wallace
b. SEX Male
c. DATE OF BIRTH Nov. 10, 1905
d. AGE 5 years 14 months 1961

4. DATE OF DEATH
Month 5 Day 14 Year 1961

5. SEX
a. Male
b. Female
c. Other

6. MARRIAGE
a. Married
b. Single
c. Widowed
d. Divorced

7. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Director of Highways
8. PLACE OF BIRTH
Baltimore City
9. CITIZENSHIP
U.S.A.

10. FATHER'S NAME
George Wallace
11. MOTHER'S MAIDEN NAME
Katie M?

12. WAS DECEASED EVER IN U.S. ARMED FORCES?
No
13. SOCIAL SECURITY NO.
2-7-7732

14. CAUSE OF DEATH (Immediately or indirectly)
PART I DEATH WAS CAUSED BY
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TO HOSPITAL: The law requires that the death certificate be executed by the attending physician within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DATE MAY 18 '61



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 15-260

1. PLACE OF DEATH a. COUNTY <u>1</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>2</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>100</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>100</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>100</u>				d. STREET ADDRESS <u>100</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W.</u> Last <u>100</u>				4. DATE OF DEATH Month <u>7</u> Day <u>19</u> Year <u>19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 14, 1900</u>	9. AGE (In years last birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>10</u> Hours <u>10</u> Min <u>0</u>		IF UNDER 24 HRS Hours <u>10</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>100</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>100</u>		11. BIRTHPLACE (State or foreign country) <u>P</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>100</u>				14. MOTHER'S MAIDEN NAME <u>100</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>100</u>		16. SOCIAL SECURITY NO. <u>100-7-100</u>		17. INFORMANT Name <u>100</u> Address <u>100</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>100</u> DUE TO (b) <u>100</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>100</u> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>100</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part of item 18) <u>100</u>					
20c. TIME OF INJURY Hour <u>10</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>100</u>		20f. (City or town) (County) (State) <u>100</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>100</u>				DATE SIGNED <u>5-21</u>			
EXAMINER'S NAME (Type) <u>Jack C. Collins</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>100</u>	22c. NAME OF CEMETERY OR CREMATORY <u>100</u>		22d. LOCATION (City, town, or county) (State) <u>100</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>100</u>				ADDRESS <u>100</u>		24a. REC'D BY REGISTRAR DATE <u>100</u>	
				24b. REGISTRAR'S SIGNATURE <u>100</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose a statement in writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5369

05361

1 PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN TB <u>17 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2 USUAL RESIDENCE (Where deceased lived first at on residence before admission) a. STATE <u>Md</u> b. COUNTY <u>06</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <u>Westminster</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>ELISHA</u> Middle <u>WEBSTER</u> Last <u>WEBSTER</u> 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>8.5.1892</u> 9. AGE (in years lost by day) <u>28</u> yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?				4. DATE OF DEATH Month <u>5</u> Day <u>19</u> Year <u>1921</u> IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> IF UNDER 24 HRS: Hours <u>1</u> Min <u>1</u>			
13. FATHER'S NAME <u>CHADICE E WEBSTER</u> 14. MOTHER'S MAIDEN NAME <u>CAROLINE KROON</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) 16. SECURITY NO. <u>24-14-6367</u> 17. INFORMANT Address				18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>Tuberculosis pleurisy with effusion</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>19</u> 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)				21 I certify that (I) (this hospital) attended the deceased from <u>5.5.1921</u> to <u>5.19.1921</u> that (I) (we) last saw the deceased alive on <u>5.12.1921</u> and that death occurred at <u>10:30 PM</u> from the causes and on the date stated above 22a SIGNATURE <u>J. M. Zimmerman</u> M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b DATE SIGNED <u>5.22.21</u> 22c PHYSICIAN'S NAME (Type)			
23a BURIAL (REMOVAL) 23b DATE THEREOF <u>5/24/21</u> 23c NAME OF CEMETERY OR CREMATORY <u>Greenview Cemetery Westminster Md</u> 23d LOCATION (City, town or county) (State) 24 FUNERAL DIRECTOR'S SIGNATURE <u>J. M. Zimmerman</u> ADDRESS <u>Westminster Md</u> 25a REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE				DATE <u>MAY 26 1921</u>			

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TO HOSPITAL/ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



CERTIFICATE OF DEATH

Reg Dist No. 05362

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Resident before admission, a STATE Maryland b COUNTY	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Pikesville		c LENGTH OF STAY IN 1b X Pikesville	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6612 Deancroft Rd.		e STREET ADDRESS 6612 Deancroft Rd.	
3 NAME OF DECEASED (Type or print) First GUSSIE Middle WEISS Last		4. DATE OF DEATH Month 5/29/61 Day Year 19	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH
9 AGE (in years last birthday) 79 yrs		F UNDER 1 YEAR Months Days Hrs Min IF UNDER 24 HRS	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Home	11 BIRTHPLACE (State or foreign country) Russia
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		INFORMANT Address Mr. Max Weiss - Mt Royal & Maryland Ave.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) coronary arterial atherosclerosis 2204 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1935 , 19 5/29/61 , to 5/29/61 , that I last saw the deceased alive on 5/29/61 , 19 1961 , and that death occurred at 3:45 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Milton B. Kirsh, M.D. 2320 Eastman Ave. Baltimore, Md. 5/29/61			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) MILTON B. KIRSH, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5/30/61	22c. NAME OF CEMETERY OR CREMATORY Chizuk Amuno Cong.	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS INC. 6010 Reist Rd.		24a. REC'D BY REGISTRAR DATE JUN 1 1961	24b. REGISTRAR'S SIGNATURE Conrad L. Thomas

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

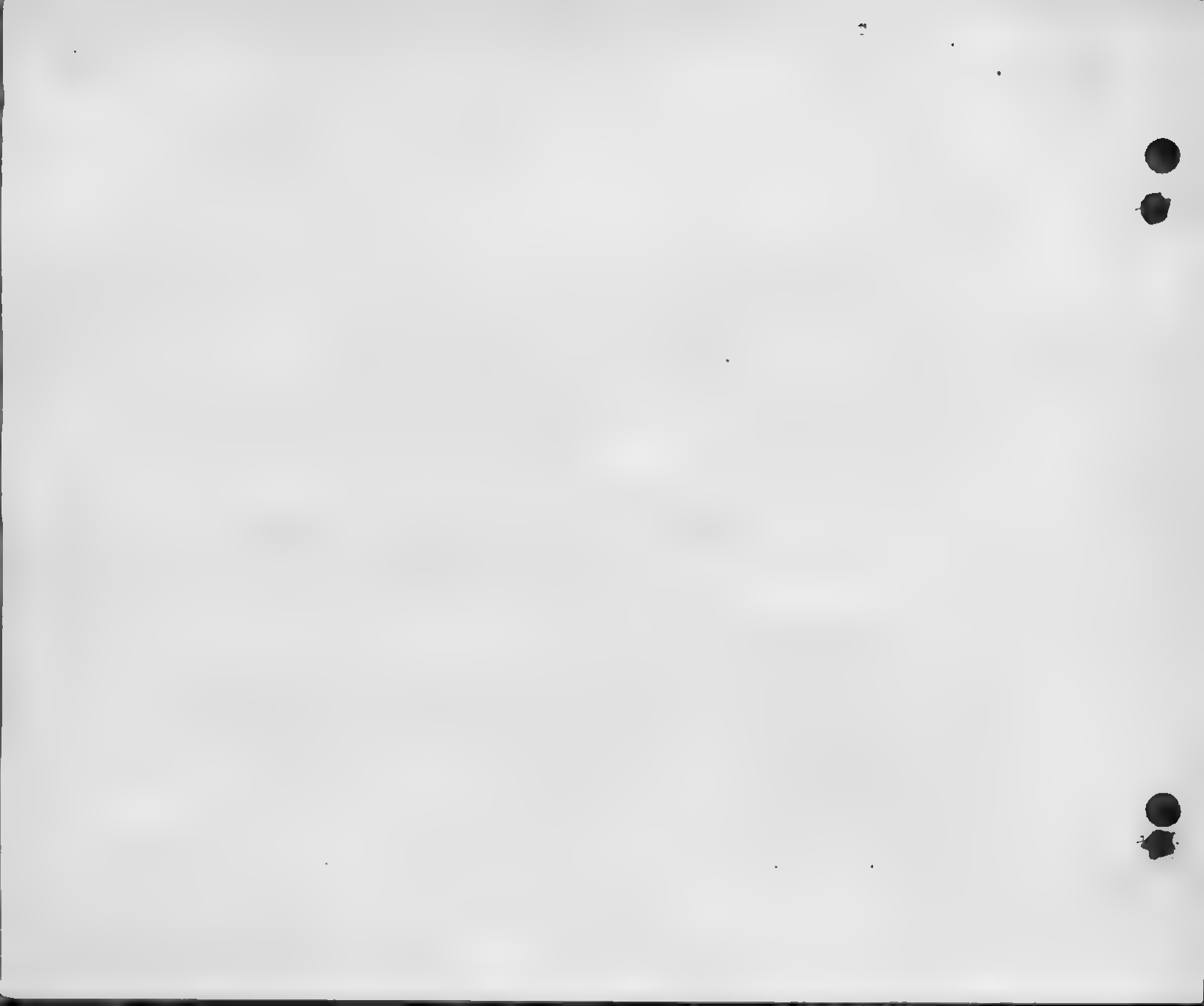
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5371

05363

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Reside elsewhere only) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (17)	
d. NAME OF HOSPITAL OR INSTITUTION, if not in hospital, give street address Veterans Administration Hospital		e. STREET ADDRESS 1403 Myrtle Avenue	
3. NAME OF DECEASED Type or print) OCEOLA WILLIAMS		4. DATE OF DEATH Month May Day 11 Year 1961	
5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH October 2, 1896	
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min. 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		11. BIRTHPLACE (Country & State) U.S. Govt. P.O. Dept. New Bern, North Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Amos Williams	
14. MOTHER'S MAIDEN NAME Lettice Gates		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I	
16. SOCIAL SECURITY NO. WW I		17. INFORMANT Clinical Records, VAH, 3900 Loch Raven Blvd. Baltimore 18, Md. FORT HOWARD DIVISION	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b. CARCINOMA OF LUNG WITH METASTASIS TO LYMPH NODES c. ARTERIOSCLEROTIC HEART DISEASE		19. INTERVAL BETWEEN ONSET AND DEATH RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. BENIGN PROSTATIC HYPERTROPHY		20. WA. AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Hour a.m. 19 p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VAH, BALTO. 18 MD. FT. HOWARD DIVISION		20g. (County) VAH, BALTO. 18 MD. FT. HOWARD DIVISION	
20h. (State) VAH, BALTO. 18 MD. FT. HOWARD DIVISION		21. I certify that (this hospital) attended the deceased from March 28, 1961 to May 11, 1961 , that (we) last saw the deceased alive on May 11, 1961 , and that death occurred at 8:35 P.M. from the causes and on the date stated above.	
22a. SIGNATURE Thomas F. Crahan, M.D.		22b. DATE SIGNED 5/12/61	
22c. PHYSICIAN'S NAME (Type or print) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTO. 18 MD. FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 5-12-61	
23c. NAME OF CEMETERY OR CREMATORY New Bern National		23d. LOCATION (City, town or county) New Bern, N.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		25a. REC'D BY REGISTRAR MAY 15 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Harris		25c. ADDRESS Baltimore 17, Md.	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01201

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince George</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c LENGTH OF STAY IN 1b <u>2</u> days	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>William B. Williams</u>		4. DATE OF DEATH Month Day Year <u>May 24 19 61</u>	
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 1, 1978</u>
9 AGE (In years last birthday) <u>53</u> yrs		IF UNDER 1 YEAR IF UNDER 2 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>farming</u>	
11 BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13 FATHER'S NAME <u>William B. Williams</u>		14 MOTHER'S MAIDEN NAME <u>Nancy McAllister</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>unknown</u>		16 SOCIAL SECURITY NO <u>unknown</u>	
17 INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Rupture of abdominal aneurysm</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, severe</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 8 1961</u> to <u>May 24 19 61</u> that I last saw the deceased alive on <u>May 24 19 61</u> , and that death occurred at <u>8:15</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachsler</u> M.D.		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>8-24-61</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>		<u>Catonsville 20, Maryland</u>	
22a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b DATE THEREOF <u>May 27, 1961</u>	22c NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	22d LOCATION (City town or county) (State) <u>Silver Spring Maryland</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.,</u> ADDRESS <u>Riverdale, Maryland.</u>		24a REC'D BY REGISTRAR DATE <u>MAY 24 1961</u>	24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The attending physician: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9 59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5373

Item 4 Film 8-667

05365

1 PLACE OF DEATH a. COUNTY Baltimore, MARYLAND		2 USUAL RESIDENCE Where deceased lived If institution Residence before admission a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore Maryland	
c. LENGTH OF STAY IN 1b 50 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address, OR INSTITUTION) Presbyterian Home, Towson		d. STREET ADDRESS 3822 Bonner Rd. Garrison Blvs	
3 NAME OF DECEASED (Type or print) First Jane Middle H Last Winterburn		4. DATE OF DEATH Month 9 Day 6 Year 19	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH Sept. 24, 1866		9. AGE (In years last birthday) 94	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) None		11. BIRTHPLACE (State or foreign country) Yorkshire, England	
13. FATHER'S NAME Richard Winterburn		14. MOTHER'S MAIDEN NAME Margaret Marsnall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO Twilah E. Elliott	
17. INFORMANT Presbyter in Home		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 days years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m. p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from January 58 to May 6 1961 that (I) (the doctor) saw the deceased alive on May 3 1961 and that death occurred on May 6 1961 at 4:15 am from the causes and on the date stated above			
22a. SIGNATURE Sidney J. Venable, Jr. M.D.		22b. ADDRESS 7215 York Road, Baltimore 12, Maryland	
22c. PHYSICIAN'S NAME (Type) Sidney J. Venable, Jr. M.D.		22d. ADDRESS 7215 York Road, Baltimore 12, Maryland	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF May 8, 1961	
23c. NAME OF CEMETERY OR CREMATORY Loriane Park		23d. LOCATION (City town or county) State Woodland, Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc.		25a. REC'D BY REGISTRAR DATE MAY 10 '61	
ADDRESS 1900 Eutaw Place Balto. 17, Md.		25b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

15266

1. PLACE OF DEATH a. COUNTY BALTIMORE CO - 28 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 8 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 616 S. Easton Str. #24	
3. NAME OF DECEASED (Type or print) First WOLF Middle MARY Last EMMA		4. DATE OF DEATH Month MAY Day 7 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-21-98
9. AGE (In years last birthday) 62 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (State or foreign country) BALTO, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID J. HAINES		14. MOTHER'S MAIDEN NAME EMMA M. ADAMS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT SISTER MARGARET C. FLURY		Address 3423 Hudson Str. Balto	
18. CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO Conditions, if any which gave rise to immediate cause (a) stating the underlying cause last (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c) DIABETES MELLITUS			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 10, 1953 to May 7, 1961 , that I last saw the deceased alive on May 7, 1961 , and that death occurred at 2:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Loretta Hsu		DATE SIGNED SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) LORETTA HSU			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 5-10 -C1.		22b. DATE THEREOF 5-10-61	
22c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.		22d. LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Harold J. ...		ADDRESS 401 S. CONKLING ST BALTO., MD.	
24a. REC'D BY REGISTRAR DATE 10 '61		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be filled out by the hospital or attending physician, or by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5375
CERTIFICATE OF DEATH

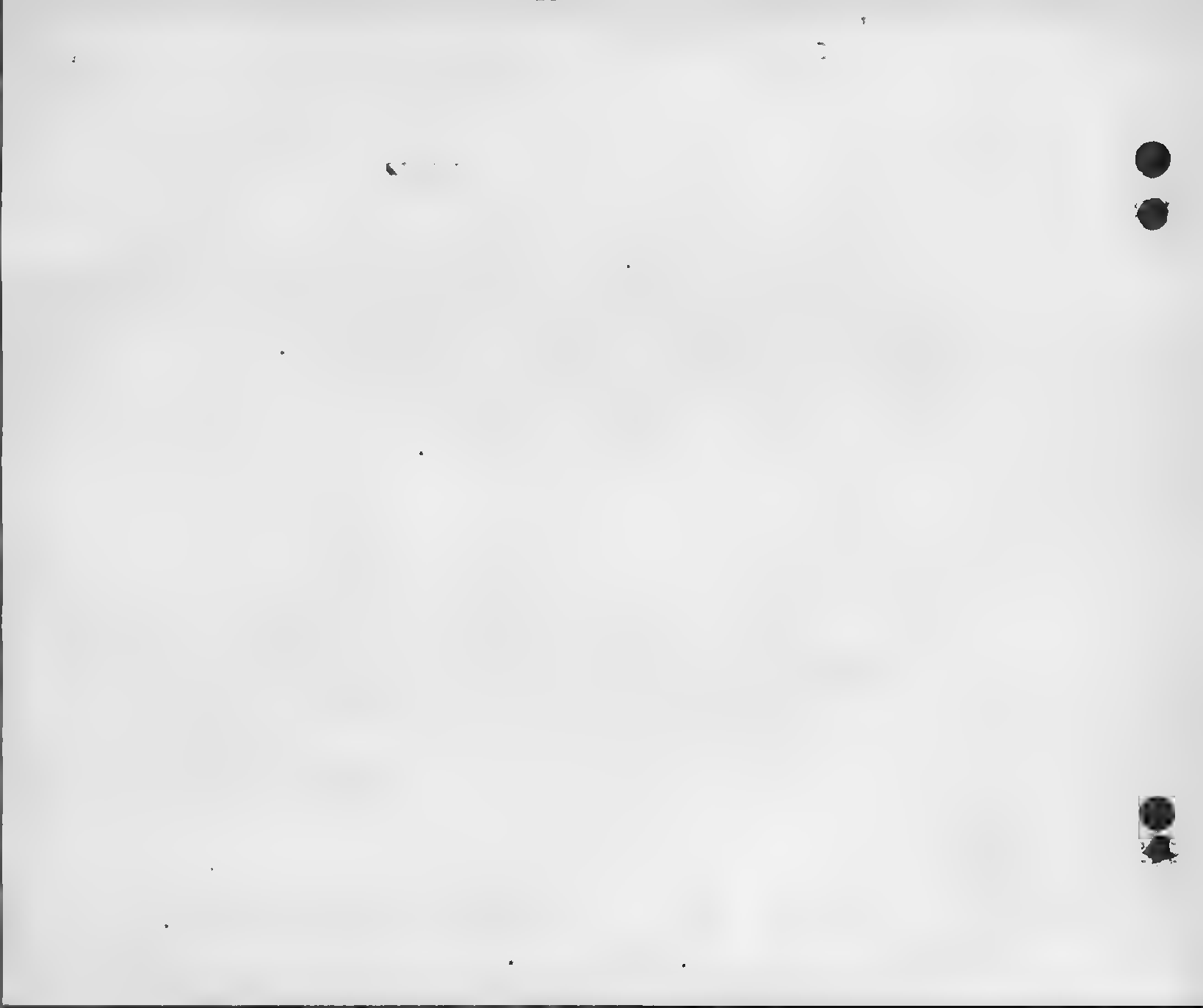
Reg. Dist. No. 15267

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE MD. b COUNTY BALTIMORE	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Luth		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 334 OLD TRAIL		e STREET ADDRESS 334 OLD TRAIL	
3 NAME OF DECEASED (Type or print) First Middle Last ROBERT L. WOOD		4 DATE OF DEATH Month Day Year MAY 23 19 61	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH OCT. 23, 1895 65
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK TRAFFIC COURT POLICE DEPT		10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE, MD.	
11 BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12 CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME WILLIAM WOOD		14. MOTHER'S MAIDEN NAME MARY MCCOLM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17 INFORMANT MRS. ROBT. L. WOOD		Address 834 OLD TRAIL	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer (b) Cancer (c) Cancer			
DUE TO Cancer			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a m p m 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I attended the deceased from May 1, 1961 to May 23, 1961 , that I last saw the deceased alive on May 23, 1961 , and that death occurred at 12:30 PM from the causes and on the date stated above			
ACTUAL SIGNATURE T Mendelis		DATE SIGNED May 24, 1961	
PHYSICIAN'S NAME (Type) T Mendelis M.D.		ADDRESS 651 N. Gentleson St. Baltimore 16 Md.	
22a BURIAL CREMATION, REMOVAL (Specify) BURIAL	22b DATE THEREOF 5/26/61	22c NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	22d LOCATION (City, town or county) (State) ARLINGTON, VA.
23 FUNERAL DIRECTOR'S SIGNATURE H.W. MEARS & SON 805 N. CALVERT ST.		24a REC'D BY REGISTRAR DATE MAY 26 1961	
24b REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. U-368

5276

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>6yr1mthd8sy</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		e. STREET ADDRESS <u>1918 Ridgehill Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Lola</u> Middle <u>Blanche</u> Last <u>Woodring</u>		4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 2, 1908</u>
9. AGE (In years last birthday) <u>52</u> yrs		10. IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min <u></u> IF UNDER 24 HRS: Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	
10a. USULA OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jonas Woodring</u>		14. MOTHER'S MAIDEN NAME <u>Frances Schendledecker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic cardiovascular disease</u>			
(c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1, 1955</u> , to <u>May 9, 1961</u> , that I last saw the deceased alive on <u>May 9, 1961</u> , and that death occurred at <u>7:25 a.m.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D.		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>5-9-61</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/12/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>		ADDRESS <u>4107 Wilkens Avenue</u>	
24a. REC'D BY REGISTRAR <u>DATE MAY 11, 1961</u>		24b. REGISTRAR'S SIGNATURE <u>S. H. Hines</u>	

MEDICAL CERTIFICATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 15269

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>1009</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1009</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MD</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1009</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Thomas</u> First <u>Thomas</u> Middle <u>Joseph</u> Last <u>Thomas</u>		4. DATE OF DEATH <u>1961</u> Year <u>10</u> Month <u>25</u> Day <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 8, 1910</u>
9. AGE (In years last birthday) <u>51</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS: Hours <u>0</u> Min. <u>0</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (State or foreign country) <u>MD</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Thomas</u>		14. MOTHER'S MAIDEN NAME <u>John Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1009</u> 17. INFORMANT <u>John Thomas</u> Address <u>1009</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1009</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>1009</u> DUE TO (b) <u>1009</u> DUE TO (c) <u>1009</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>1009</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>1009</u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>10</u> a. m. <u>00</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1009</u> 20f. (City or town) <u>Baltimore</u> (County) <u>MD</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Leo M. Kieffer</u> M.D. EXAMINER'S NAME (Type) <u>Leo M. Kieffer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/29/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u> ADDRESS <u>4107 Wilkens Avenue</u>		24a. REC'D BY REGISTRAR <u>29 61</u> DATE <u>29 61</u>	
24b. REGISTRAR'S SIGNATURE <u>Leo M. Kieffer</u>		24c. REGISTRAR'S SIGNATURE <u>Leo M. Kieffer</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director or to the Chief Medical Examiner's Office along with form BM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11-3711

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY in 1b 16 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if not at residence at date of death) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylor's Island d. STREET ADDRESS P.O. Box 101,	
3. NAME OF DECEASED First Middle Last JULIAN E. YOST Type or print		4. DATE OF DEATH Month Day Year May 12 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 24, 1899	
9. AGE In years 62 yrs IF UNDER 1 YEAR: Months 62 Days 12 Hours 19 Min 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police Officer 11. BIRTHPLACE County & State or foreign country District of Col. Cleveland, Ohio 12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William E. Yost		14. MOTHER'S MAIDEN NAME Rachael Groves	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 578-26-4096 17. INFORMANT Address Clinical Records, VAH, Baltimore 13, Maryland Fort Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE is BRONCHOPNEUMONIA DUE TO CONGESTIVE HEART FAILURE b. ADENOCARCINOMA OF THE LEFT LUNG WITH METASTASIS TO LIVER AND AXILLARY LYMPH NODES c. TO LIVER AND AXILLARY LYMPH NODES PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Hypertrophy and Dilatation of the Heart - Unknown			
19. WA. AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20. TIME OF INJURY Month, Day Year April 26 1961 to May 12 1961 Hour a.m. 12:10 p.m. P.M. 20c. INJURY OCCURRED 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
21. I certify that (This hospital) attended the deceased from April 26 1961 to May 12 1961, that (he) (we) last saw the deceased alive on May 12 1961, and that death occurred at P.M. from the causes and on the date stated above.			
22a. SIGNATURE Jack C. Lewis 22c. PHYSICIAN'S NAME (Type) JACK C. LEWIS M.D.		22b. DATE SIGNED 5-13-61 22d. ADDRESS VAH Baltimore 13 Md - Ft Howard Division	
23a. BURIAL CREMATION REMOVAL (Specify) Removal		23b. DATE THEREOF MAY 16, 1961	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Hysong's Funeral Home 1500 1st St W Washington D C		25a. REC'D BY REGISTRAR MAY 15 '61	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and for any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5373

05371

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY (in days) 75 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore g. STREET ADDRESS 432 East 32nd Street	
3. NAME OF DECEASED (Type or print) ROBERT YOUNG 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH June 5, 1888 9. AGE (In years, last birthday) 72 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant 11b. KIND OF BUSINESS OR INDUSTRY Garage 12. CITIZEN OF WHAT COUNTRY? U. S. A.		4. DATE OF DEATH May 31 19 61 13. FATHER'S NAME Charles Young 14. MOTHER'S MAIDEN NAME Anne Fenton 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I 16. SOCIAL SECURITY NO. 096-07-8861 17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE RETICULUM CELL SARCOMA INVOLVING THE LEFT ILIAC XXX AND PERIAORTIC LYMPH NODES, BOTH LUNGS AND THE XX URINARY BLADDER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DU E TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE ONSET ON GIVEN REPORT EDEMA OF THE LUNGS. MALNUTRITION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) County State		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 YEARS 19. WAS A POSTMORTEM PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 17 1961 , to May 31 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 31 1961 , and that death occurred at 2:10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Fredrick S. Donaldson, M.D. FREDERICK S. DONALDSON, M.D. 22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> 22d. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 16/5/61 23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Baltimore 23d. LOCATION (City, town or county) 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck & Sons, 5305 Harford Rd. Balto. 14		25a. REC'D BY REGISTRAR DATE JUN 1 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Finaud	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5380

05372

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 2 MO.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY FREDERICK CO.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) of the live-in personnel employed here BRADDOCK HEIGHTS		d. STREET ADDRESS Jefferson Bldg 10X-1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANDREAS		First		Middle		Last ZAJACZ		4. DATE OF DEATH Month MAY		Day 5		Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/27/32		9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months 28		IF UNDER 24 HRS. Days 28		Hours 28	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAUNDRY WORKER		10b. KIND OF BUSINESS OR INDUSTRY NURSING HOME		11. BIRTHPLACE (State or foreign country) HUNGARY		12. CITIZEN OF WHAT COUNTRY? Hungary ???									
13. FATHER'S NAME JOSEPH ZAJACZ		14. MOTHER'S MAIDEN NAME JULIA JURKINIA													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-42-1259		17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA DUE TO ACUTE CARDIAC FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)												INTERVAL BETWEEN ONSET AND DEATH 1 DAY			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 3/10 , 19 61 , to 5/5 , 19 61 , that (I) (we) last saw the deceased alive on 5/5 , 19 61 , and that death occurred at 230 A.M., from the causes and on the date stated above.															
22a. SIGNATURE M. Newcomer		22b. PHYSICIAN'S NAME (Type) M. Newcomer, M.D. Superintendent		22c. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.		22d. DATE SIGNED 5/5/61		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-9-1961		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) Frederick, Maryland									
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Spiller		24a. ADDRESS Frederick, Md.		25a. REC'D BY REGISTRAR DATE MAY 8 '61		25b. REGISTRAR'S SIGNATURE Charles L. Kneass									

220-1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5381

CERTIFICATE OF DEATH

05373

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex (21)</u>		c. LENGTH OF STAY IN It <u>X</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex (21)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>212 Margaret Ave.</u>		d. STREET ADDRESS <u>212 Margaret Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>PAUL ZIEMBA</u>		4. DATE OF DEATH <u>May 13, 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 16, 1892</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe Straightener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Mill</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Ziemba</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wojtowicz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO. <u>213-09-0228</u>	
17. INFORMANT <u>Melen Ziemba</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic pulmonary carcinoma</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/1, 1961</u> , to <u>5/13, 1961</u> , that I last saw the deceased alive on <u>5/11, 1961</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Blatt</u>		ADDRESS (Street, city or town, state) <u>434 Eastern Ave</u> DATE SIGNED <u>5/15/61</u>	
PHYSICIAN'S NAME (Type) <u>J. BLATT, M.D.</u>		<u>East. Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/16/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George E. Brzezinski</u> ADDRESS <u>1107 Eastern Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 16 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Charles L. Hines</u>

IN SENATE,
January 10, 1900.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
FOR THE YEAR
1899.
BY
J. M. HARRIS,
COMMISSIONER.
DALLAS: THE TEXAS PRINTING CO., 1900.

